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In The

Supreme Court of the United States

October Term, 1997

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, a California non-profit public benefit corporation, d/b/a BEVERLY HOSPITAL, *et al.*,

Petitioners,

vs.

S. KIMBERLY BELSHÉ, Director of the California Department of Health Services,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

JOHN R. HELLOW
Counsel of Record
BYRON J. GROSS
HOOPER, LUNDY & BOOKMAN, INC.
Attorneys for Petitioners
1875 Century Park East
Suite 1600
Los Angeles, CA 90067
(310) 551-8111

146489

(800) 274-3321 • (800) 359-6859
A DIVISION OF COUNSEL PRESS

Lutz Appellate Services, inc.

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QUESTIONS PRESENTED

This case addresses the extent of the obligation of state Medicaid programs to pay the Medicare deductibles and co-insurance ("cost-sharing") for certain low-income Medicare beneficiaries who are designated as Qualified Medicare Beneficiaries. The precise questions presented to the Court are as follows:

A. Whether the United States Courts of Appeals for the Ninth Circuit erred in ignoring four other Courts of Appeals decisions holding that 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p)(3) clearly require states to pay full Medicare cost-sharing for Qualified Medicare Beneficiaries, by deferring to Section 4714 of the Balanced Budget Act of 1997, so-called "clarifying" legislation enacted by Congress more than 10 years after the statutes in question were enacted, and after the services in question were rendered by health care providers?

B. Whether the Separation of Powers Doctrine, based in this case on Article III of the United States Constitution, prohibits Congress from directing the outcome of this case and other pending litigation in a manner beneficial to the government, by the retroactive application of Section 4714(a) of the Balanced Budget Act of 1997 only to such litigants?

C. Whether the retroactive application of Section 4714 of the Balanced Budget Act of 1997 to payment for health care services already provided impairs vested property rights protected by the Just Compensation Clause of the Fifth Amendment to the United States Constitution?

PARTIES TO THE PROCEEDINGS

Parties to this proceeding are all hospitals providing inpatient hospital services to California residents who are Qualified Medicare Beneficiaries not listed in the caption ("QMBs"). The named representative hospitals not listed in the caption are:

BELLWOOD MEDICAL CORPORATION, d/b/a BELLWOOD GENERAL HOSPITAL; CHICO COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a CHICO COMMUNITY REHABILITATION HOSPITAL, d/b/a CHICO COMMUNITY HOSPITAL; HOLLYWOOD COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS, d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD; LANCASTER HOSPITAL CORPORATION, d/b/a LANCASTER COMMUNITY HOSPITAL, LINCOLN COMMUNITY MEDICAL CORPORATION, d/b/a Orange County Community Hospital of Orange; MONROVIA HOSPITAL CORPORATION, d/b/a Monrovia Community Hospital; PARACELSUS LOS ANGELES COMMUNITY HOSPITAL, INC., d/b/a Los Angeles Community Hospital of Los Angeles and Los Angeles Community Hospital of Norwalk; MISSION HOSPITAL REGIONAL MEDICAL CENTER, a California non-profit corporation; QUEEN OF THE VALLEY HOSPITAL OF NAPA, CALIFORNIA, a California non-profit corporation; REDWOOD MEMORIAL HOSPITAL OF FORTUNA, a California non-profit corporation; ST. JOSEPH HOSPITAL OF EUREKA, a California non-profit corporation; ST. JOSEPH HOSPITAL OF ORANGE, a California non-profit corporation; ST. JUDE HOSPITAL, INC., a California non-profit corporation, d/b/a St. Jude Medical Center; ST. MARY DESERT VALLEY HOSPITAL, a California non-profit corporation; SANTA ROSA MEMORIAL HOSPITAL, a California non-profit corporation; NME HOSPITALS, INC.,

d/b/a Doctors Hospital of Montero, Community Hospital and Rehabilitation Center of Los Gatos, Redding Medical Center, Garfield Medical Center, Doctors Medical Center, Modesto, Doctors Hospital of Pinole, John F. Kennedy Memorial Hospital, Los Alamitos Medical Center, Century City Hospital, Lakewood Regional Medical Center, Alvarado Medical Center, Placentia Circle Community Hospital, Twin Cities Community Hospital, San Ramon Regional Medical Center, and USC University Hospital; REHABILITATION FACILITY AT SAN RAMON, INC., a California corporation, d/b/a Golden State Rehabilitation Hospital; R.H.S.C. MODESTO, INC., a California corporation, d/b/a Rehabilitation Hospital of Modesto; NATIONAL MEDICAL SPECIALTY HOSPITAL OF REDDING, a California corporation, d/b/a Redding Specialty Hospital; REHABILITATION FACILITY AT SAN DIEGO, INC., a California corporation, d/b/a San Diego Rehabilitation Institute at Alvarado; MEDICAL CENTER OF GARDEN GROVE, INC., d/b/a Garden Grove Hospital; SAN DIMAS COMMUNITY HOSPITAL, INC., d/b/a San Dimas Community Hospital; AMISUB (Sierra Vista), INC., d/b/a Sierra Vista Regional Medical Center; NEW H SOUTH BAY, INC., d/b/a South Bay Community Hospital; AMI/HTI TARZANA ENCINO JOINT VENTURE, d/b/a Tarzana Regional Medical Center and Encino Hospital; AMISUB OF CALIFORNIA, INC., d/b/a Valley Doctors Hospital a/k/a Medical Center of North Hollywood; AMISUB (IRVINE MEDICAL CENTER, INC.), d/b/a Irvine Medical Center; CHINO COMMUNITY HOSPITAL CORPORATION, INC., d/b/a Chino Community Hospital; HUNTINGTON INTERCOMMUNITY HOSPITAL, d/b/a Huntington Beach Medical Center, f/k/a HH-Huntington Beach; LAS ENCINAS HOSPITAL, d/b/a Las Encinas Hospital; LOS ROBLES REGIONAL MEDICAL CENTER, d/b/a Los Robles Regional Medical Center; SLCO, INC., d/b/a San Leandro Hospital, f/k/a HH-San Leandro; WEST ANAHEIM COMMUNITY HOSPITAL, d/b/a West Anaheim Medical

Center, f/k/a HH-West Anaheim; WEST HILLS HOSPITAL, d/b/a West Hills Regional Medical Center, f/k/a HH-West Hills; HEALDSBURG GENERAL HOSPITAL, INC., d/b/a Healdsburg General Hospital; WEST LOS ANGELES PHYSICIANS HOSPITAL, INC., d/b/a Westside Hospital; MISSION BAY MEMORIAL HOSPITAL, INC., d/b/a Mission Bay Memorial Hospital; SEBASTOPOL HOSPITAL CORPORATION, d/b/a Palm Drive Hospital; ON BEHALF OF THEMSELVES AND ALL SIMILARLY SITUATED HOSPITALS.

STATEMENT PURSUANT TO RULE 29.6

As to named class members, information regarding parents or non wholly owned subsidiaries is as follows:

A. Paracelsus Healthcare Corporation is a publicly traded company and has an ownership interest in the following subsidiary corporations which are members of the class: Bellwood Medical Corporation, Chico Community Hospital Medical Center, Inc., Hollywood Community Hospital Medical Center, Inc., Lancaster Hospital Corporation, Lincoln Community Medical Corporation, Monrovia Hospital Corporation, and Paraceleus Los Angeles Community Hospital, Inc.

B. Tenet Healthcare Corporation, Inc. is a publicly traded company whose subsidiary corporation, NME Hospitals, Inc., is a named plaintiff that does business under the following hospital names: Doctors Hospital of Montero, Community Hospital and Rehabilitation Center of Los Gatos, Redding Medical Center, Garfield Medical Center, Doctors Medical Center, Modesto, Doctors Hospital of Pinole, John F. Kennedy Memorial Hospital, Los Alamitos Medical Center, Century City Hospital, Lakewood Regional Medical Center, Alvarado Medical Center, Placentia Circle Community Hospital, Twin Cities Community Hospital, San Ramon Regional Medical Center, and USC University Hospital. Additionally, Tenet Healthcare Corporation, Inc. is the parent company of The Rehabilitation Facility at San Ramon, Inc., RHSC Modesto, Inc., National Medical Specialty Hospital of Redding, Rehabilitation Facility at San Diego, Inc., Medical Center of Garden Grove, Inc., San Dimas Community Hospital, Inc., AMISUB, Inc., New H South Bay, Inc., AMI\HTI Tarzana-Encino Joint Venture, AMISUB of California, Inc., AMISUB (Irvine Medical Center, Inc.).

C. Columbia\HCA Healthcare Corporation, a publicly traded corporation, is the parent or affiliate of the following corporations which are listed as representative members of the class: Chino Community Hospital Corporation, Inc., Huntington Intercommunity Hospital, Las Encinas Hospital, Los Robles Regional Medical Center, SLCO, Inc., West Anaheim Community Hospital, West Hills Hospital, Healdsburg General Hospital, Inc., West Los Angeles Physicians Hospital, Inc., Mission Bay Memorial Hospital, Inc., Sebastopol Hospital Corporation.

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Beverly Community Hospital Association, *et al.*, (collectively "Hospitals" or "Petitioners") on behalf of a class consisting of similarly situated hospitals, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in favor of respondent, S. Kimberly Belshé, as Director of the California Department of Health Services ("California").

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Ninth Circuit (App. A) is reported at 132 F.3d 1259 (9th Cir. 1997). The judgment of the United States District Court for the Central District of California (App. B) and its subsequent order (App. C) are also unreported. The denial of rehearing and the denial of the suggestion for rehearing *en banc* (App. D) are unreported.

STATEMENT OF JURISDICTION

The Court of Appeals entered its judgment on December 2, 1997. (App. A). A petition for rehearing and suggestion for rehearing *en banc* (App. D) was rejected on March 3, 1998. (App. D). Congress granted the Court jurisdiction over such final judgments by writ of certiorari pursuant to 28 U.S.C. § 1254(1). Because 28 U.S.C. § 2403(a) may apply, pursuant to Rule 29.4(b), Petitioners are concurrently serving the Solicitor General of the United States with this Petition.

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

The following Constitutional provisions are involved in this case: Article III, and the Just Compensation Clause of the Fifth Amendment. The following statutes are involved in this case: 42 U.S.C. §§ 1396a(a)(10)(E)(i), 1396a(n), and 1396d(p)(3). The Balanced Budget Act of 1997, Pub. L. 105-33, § 4714, 111 Stat. 251, 509-10 (1997) is also involved in this case.

STATEMENT OF THE CASE

This case addresses the extent of state Medicaid agency obligations under the Social Security Act to pay the Medicare deductibles and co-insurance ("cost-sharing") for certain low income persons known as Qualified Medicare Beneficiaries ("QMBs"). QMBs, who may be eligible for the full scope of Medicaid benefits or only Medicare cost-sharing payments, are "bought in" to the Medicare program by state Medicaid payment of their premiums.

In June 1995, a class, consisting of all hospitals that provide inpatient services to California's QMBs (the "Hospitals"), filed suit in the United States District Court for the Central District of California challenging California's refusal to pay, through its Medi-Cal program,[1] any of the Medicare cost-sharing associated with inpatient hospital services provided to QMBs.[2] Medi-Cal's refusal to make the cost-sharing payments to hospitals for their inpatient services represented an annual reduction of approximately $130 million in payments to hospitals, which are prohibited under federal and state law from turning to the QMBs for payment of the Medicare cost-sharing.

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1. "Medi-Cal" is California's version of Medicaid, which is a cooperative federal-state program established to provide medical care to low-income individuals and families. 42 U.S.C. § 1396 *et seq.* (1995); Cal. Welf. & Inst. Code § 14000 *et seq.* (1996).

2. That policy, effective May 1, 1994, is similar to Medi-Cal's refusal to pay full Medicare cost-sharing for physician services and ambulance services, which is the subject of the companion cases heard by the Ninth Circuit at the same time as this case, *California Ambulance Ass'n v. Shalala* ("CAA"), *California Medical Ass'n v. Shalala* ("*CMA*"), and *Gilmore v. Shalala* ("*Gilmore*") (the "Related Cases"). One opinion was issued by the Ninth Circuit for the related cases and this case. 132 F.3d 1259. Petitions for Certiorari are being filed concurrently with this case in the *CAA* and *CMA* cases (which are consolidated) and in the *Gilmore* case.

The Hospitals relied on two provisions of the Social Security Act to support their claim to full cost-sharing payments from Medi-Cal: 42 U.S.C. § 1396a(a)(10)(E)(i), which requires state Medicaid programs to pay Medicare cost-sharing for QMBs, and 42 U.S.C. § 1396d(p)(3), which defines Medicare cost-sharing to include premiums, deductibles and coinsurance, without any limitation. Four United States Courts of Appeals had held already that those provisions clearly required state Medicaid programs to make full cost-sharing payments. *Rehabilitation Ass'n of Virginia v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994), *cert. denied*, 516 U.S 811, 116 S. Ct. 60, 133 L. Ed. 2d 23 (1995) ("*Kozlowski*"); *Haynes Ambulance Serv., Inc. v. State of Alabama*, 36 F.3d 1074 (11th Cir. 1994) ("*Haynes*"); *Pennsylvania Medical Society v. Snider*, 29 F.3d 886 (3d Cir. 1994) ("*Snider*"); *New York City Health and Hosps. Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992), *cert. denied*, 506 U.S. 972, 113 S. Ct. 461, 121 L. Ed. 2d 369 (1992) ("*Perales*") (hereinafter referred to in the aggregate as the "Four Circuits").

The District Court below, Judge Spencer Letts, following the opinions of the Four Circuits, granted summary judgment and a permanent injunction in favor of the Hospitals effective December 11, 1995, requiring Medi-Cal to make the full Medicare cost-sharing payments associated with hospital inpatient services. Defendant S. Kimberly Belshé, Director of the California Department of Health Services, the State Medi-Cal agency, complied with the injunction, but appealed the decision to the Ninth Circuit. The State subsequently appealed decisions by the same District Court judge in the cases pertaining to the Related Cases; those appeals were considered concurrently with this case.

Prior to oral argument before the Ninth Circuit, Congress enacted Section 4714 of the Balanced Budget Act of 1997 ("BBA"), Pub. L. No. 105-33 (App. E), which became effective on August 5, 1997. Section 4714 provides that state Medicaid agencies are

not required to pay Medicare cost-sharing for QMBs to the extent that such a payment would exceed what would otherwise be paid under the State Medicaid plan for the same item or service if provided to an eligible Medicaid recipient who is not a Medicare beneficiary. (*See* App. E). The parties do not dispute that from the date of enactment, August 5, 1997, states may limit the payment of cost-sharing for QMBs to the level of their Medicaid rates, even if the full Medicare payment for the service would be higher.

In addition to making Section 4714(a) effective for items and services provided on or after August 5, 1997, Congress stated in Section 4714(c) that the amendments affecting the states' cost-sharing obligation shall apply to payments for preenactment services, but only if such payments are the subject of a lawsuit pending as of, or initiated after, that date. Thus, shortly before this matter reached the Ninth Circuit, the legal landscape had changed. The Ninth Circuit appeared obliged not only to consider the original state of the law, but also the possible impact of Section 4714 on the state of the law prior to its enactment.

The Ninth Circuit issued its decision on December 2, 1997, writing a single opinion for this and the Related Cases. *Beverly Community Hosp. Ass'n v. Belshé*, 132 F.3d 1259 (9th Cir. 1997). "Eschewing any analysis" of the parties' arguments regarding the pre-BBA state of the law, and relying on its belief that clarity is generally absent from the Medicare and Medicaid statutes as a whole, the Ninth Circuit held that the pre-BBA law was ambiguous and that Section 4714 is a clarification of what the law always meant. 132 F.3d at 1264, 1266-67. Accepting the "clarification" as a statement of existing law, the court rejected without consideration the Hospitals' claims that the retroactive application of Section 4714 solely to payment for preenactment services subject to litigation violates separation of powers principles founded in Article III of the United States Constitution, and represents an unlawful taking under the Just Compensation Clause of the Fifth

Amendment. Based on the Ninth Circuit's decision, California now has the authority to recoup hundreds of millions of dollars which were paid to hospitals pursuant to the District Court's injunction.

On March 3, 1998, the Ninth Circuit denied the Hospitals' petition for rehearing and suggestion for rehearing *en banc*.

REASONS FOR GRANTING THE WRIT

I. IN FINDING THAT DEFERENCE SHOULD BE GIVEN TO SECTION 4714 OF THE BALANCED BUDGET ACT OF 1997 BECAUSE EARLIER ENACTMENTS WERE UNCLEAR, THE DECISION BELOW, AND THE SEVENTH CIRCUIT'S DECISION IN *PARAMOUNT HEALTH SYSTEMS, INC. v. WRIGHT*, CONFLICT WITH DECISIONS OF THE SECOND, THIRD, FOURTH AND ELEVENTH CIRCUITS HOLDING THAT 42 U.S.C. § 1396a(a)(10)(E)(i) AND 42 U.S.C. § 1396d(p)(3) UNAMBIGUOUSLY REQUIRE STATES TO PAY FULL MEDICARE COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES. THE PETITION SHOULD BE GRANTED TO RESOLVE THAT CONFLICT, AS WELL AS TWO CONFLICTING LINES OF SUPREME COURT CASES REGARDING THE DEGREE OF DEFERENCE TO BE GIVEN TO LEGISLATION WHICH PURPORTS TO INTERPRET EARLIER CONGRESSIONAL ENACTMENTS.

Both the Ninth Circuit and the Seventh Circuit reversed lower court decisions favorable to healthcare providers by deferring to Section 4714 as a clarification of longstanding Social Security Act provisions relating to state Medicaid payment obligations for QMB cost-sharing.[3] The Ninth Circuit indicated that it would have

3. *Beverly*, 132 F.3d 1259; *Paramount Health Systems v. Wright*, 138 F.3d 706 (7th Cir. 1998) ("*Paramount*"). It is the Hospitals' understanding (Cont'd)

considered the Hospital's constitutional arguments criticizing the application of Section 4714 to preenactment services if it had found the prior law clear. 132 F.3d at 1265. The Seventh Circuit went further, suggesting that it might have *accepted* the providers' constitutional arguments if it had not found the statutory scheme ambiguous and if it was not obliged, under certain Supreme Court precedent, to defer to Congress' "clarification." *Paramount*, 138 F.3d at 710. In finding statutory ambiguity, the Ninth and Seventh Circuit decisions directly conflict with the earlier decisions of the Four Circuits — the Second, Third, Fourth and Eleventh — which, without the influence of Congress' recent intervention, held that the Social Security Act *unambiguously* required states to pay full Medicare cost-sharing for QMBs.

In deferring to Section 4714 as a clarification of prior law, the court below relied on *Loving v. United States*, 517 U.S. 748, 770, 116 S. Ct. 1737, 1749, 135 L. Ed. 2d 36 (1996) and other decisions of this Court which have accorded great weight to legislation said to express the intent of an earlier statute. 132 F.3d at 1265. The *Paramount* decision, however, noted that there is a contrary line of decisions by this Court, exemplified by *United States v. Philadelphia National Bank*, 374 U.S. 321, 348-49, 83 S. Ct. 1715, 1733, 10 L. Ed. 2d 915 (1963), and most recently reaffirmed in *South Dakota v. Yankton Sioux Tribe*, 118 S. Ct. 789, 139 L. Ed. 2d 773 (1998), wherein the Court stated that the "views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one."[4] While feeling constrained to follow the

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(Cont'd)
that the providers in *Paramount* intend to file a petition for writ of certiorari within the next few weeks.

4. *See also United States v. Estate of Francis J. Romani*, 118 S. Ct. 1478, 1479, 66 U.S.L.W. 4295, 4300 (1998) ("The Constitution puts Congress in the business of writing new laws, not interpreting old ones. '[L]ater enacted laws . . . do not declare the meaning of earlier law.' " (Scalia, J. concurring)).

Loving line of cases, Judge Posner in *Paramount* invited the Court to definitively resolve the conflict between these two divergent lines of cases. 138 F.3d at 710-11.

A. There is Conflict Among the Circuits Regarding the Clarity of Prior Law.

The Four Circuits analyzed the statutes under the familiar principles of *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 104 S. Ct. 2778, 81 L. Ed. 2d 694 (1984). Under *Chevron*, courts only defer to an agency interpretation of a statute if Congressional intent is not clear. All Four Circuits, in lengthy and considered opinions, held that the statutory language and contemporaneous legislative history indicated unambiguous Congressional intent, and thus never reached the second step of *Chevron*.

The court below essentially abdicated its judicial responsibilities by skipping over the first step of *Chevron* entirely. In fact, the court baldly stated that it was "eschew[ing] any analysis" of the meaning and history of the statutes at issue, because of Congress' intervening "clarification." 132 F.3d at 1264. Astonishingly, the court does not even cite the two statutes which are the foundation of the Hospitals' argument and the basis for the decisions of the Four Circuits: 42 U.S.C. §§ 1396a(a)(10)(E)(i) and 1396d(p)(3).[5] Similarly, the Seventh Circuit, while making more of an effort than the Ninth Circuit to actually look at the pre-BBA state of the law, premised its conclusion that the statutes were ambiguous on an incomplete and inaccurate analysis.

The mandatory payment obligation on behalf of QMBs is found at Section 1396a(a)(10)(E)(i):

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5. The court's statement, later in its opinion, that it made an effort "to parse the intricate and complex provisions of the pre-Act legislation" is unconvincing, as none of this analysis appears in the opinion. 132 F.3d at 1266-67.

> [The state Medicaid plan must provide] for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title. . . .

42 U.S.C. § 1396a(a)(10)(E)(i) (App. E). Section 1396d(p)(3) defines Medicare cost-sharing to include premiums, coinsurance and deductibles. 42 U.S.C. § 1396d(p)(3) (App. E). Neither the requirement that states pay the Medicare cost-sharing nor the definition of the cost-sharing which must be paid includes any qualifications whatsoever.

These statutes were first enacted in 1986.[6] Legislative history

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6. The history and development of the relevant statutes is somewhat lengthy and has been discussed in great detail in the opinions issued by the Four Circuits. *See, e.g., Kozlowski*, 42 F.3d at 1450-58. Essentially, prior to 1986, states, for almost 20 years, were required to make Medicare cost-sharing payments for "dual eligibles," those persons who were eligible for benefits under both the Medicare and state Medicaid programs. The basis for this obligation was 42 U.S.C. § 1396a(a)(15) (repealed 1988), which provided for full cost-sharing except for a charge which the state could make to the beneficiaries themselves based on their income and resources. In 1986, Congress established a new category of Medicare beneficiary, the QMBs, who were not quite poor enough to meet Medicaid eligibility requirements, but for whom states could "buy in" to the Medicare program by paying their Medicare premiums, deductibles and co-insurance. Aside from these items, the QMBs (sometimes referred to as "pure QMBs") did not receive regular Medicaid benefits. Sections 1396a(a)(10)(E)(i) and 1396d(p)(3) set forth the states' obligation to pay the cost-sharing for QMBs, which was a state option in 1986 and became mandatory in 1988. Likewise, in 1988, the "dual eligibles" were merged into the definition of QMBs, which since then has covered all Medicare beneficiaries who are poor enough to meet the QMB income and resource guidelines, regardless of whether they meet the Medicaid guidelines as well. Thus, since 1988, Sections 1396a(a)(10)(E)(i) and 1396d(p)(3) have controlled the states' cost-sharing obligation for dual

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contemporaneous with the enactment of these statutes is consistent with the clear language of the statutes and fully supports the Hospitals' position that the states' cost-sharing obligation is mandatory and unqualified.[7] This is consistent with Congress's goal to expand medical coverage for persons under the poverty line by allowing, and later mandating, states to buy these persons into the Medicare program, without extending full Medicaid coverage to these persons, which would have been much more

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eligibles and "pure" QMBs alike. In 1988, Congress also removed the provision which allowed states to charge dual eligibles a small amount based on their income and resources. Since then, for all QMBs, states may charge a "nominal" amount. 42 U.S.C. § 1396o.

7. The House Report, outlining the scope of the new QMB program, stated that states "would be permitted to pay just for the Medicare Part B premium and the other Parts A and B cost-sharing requirements for Medicare beneficiaries." H.R. Rep. No. 99-727, 99th Cong. 2d Sess. at 105 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3695. Nothing in the surrounding discussion indicates that the states would be allowed to discretionarily *limit* the amount of cost-sharing they paid. *See Kozlowski*, 42 F.3d at 1455. Moreover, the House Report provided an example for how state Medicaid programs would be required to pay the cost-sharing amounts for QMBs, referencing Part B physician services:

> . . . for elderly and disabled individuals whom the state chose to cover, the Medicaid program would pay for the Part B deductible and the beneficiary's 20% coinsurance on Part B services. If the beneficiary uses a physician that takes assignment, Medicaid would pay the physician directly for the 20% coinsurance, and the patient could not be billed for any amounts above the Medicare reasonable charge.

H.R. Rep. No. 99-727, 99th Cong. 2d Sess. at 106 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3696. This clearly indicates that physicians (and other providers) could expect to receive full payment for the QMBs whom the states were buying into the Medicare program.

expensive for the states. *See* H.R. Rep. No. 99-727, 99th Cong., 2d Sess. at 106 (1986), reprinted in 1986 U.S.C.C.A.N. 3607, 3696.

These clear statutory provisions and supporting contemporaneous legislative history are consistent with the Hospitals' position.[8] Unfortunately, they were ignored by the Ninth Circuit.[9] Rather than analyze the statutes in question, the Ninth Circuit appears to have thrown up its hands and expressed its frustration that "any quality of crystal clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes." 132 F.3d at 1266. Under the opinion's logic, the entirety of legislation for two federal programs becomes ambiguous, allowing federal and state agencies free reign to interpret those provisions as they see fit. That is clearly an unacceptable result.

Besides its general reluctance to wade into the statutory scheme, the Ninth Circuit focused on a provision of the Social Security Act, 42 U.S.C. § 1396a(n), which has been relied on by the state and federal defendants in all the litigation on this issue as a basis for limiting states' cost-sharing obligations. This provision was

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8. If any legislative history is to be considered in construing statutory meaning, this Court has held that it is preferable to consult the documents prepared by Congress when deliberating. *Gustafson v. Alloyd Co. Inc.*, 513 U.S. 561, 580, 115 S. Ct. 1061, 1072, 131 L. Ed. 2d 1 (1995). Some inconsistent post-enactment legislative history was considered by the Four Circuits, but rejected as unpersuasive. *See Kozlowski*, 42 F.3d at 1456-57 ("This wrenching change to a statute's meaning that had been stable for 20 years points precisely to the pitfalls of relying on 'post enactment legislative history' which Justice Scalia recently has characterized, quite appropriately, as an oxymoron."); *See also Haynes*, 36 F.3d 1076 (following *Snider*, 29 F.3d 886, and adopting its rationale); *Snider*, 29 F.3d at 898; *Perales*, 954 F.2d at 861.

9. The Seventh Circuit agreed with the providers that the requirement that states reimburse providers at the full Medicare level of payment can be naturally inferred from the statutory language. *Paramount*, 138 F.3d at 708.

carefully considered by the Four Circuits, which unanimously found that the underlying, mandatory obligation to pay full cost-sharing was unaffected by Section 1396a(n)'s terms.

Section 1396a(n) sets forth the following language:

> In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII [Medicare] of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

See App. E. This statute declares that a state "may" make cost-sharing payments for QMBs which, together with the payment made by the Medicare program, can cause total payments to exceed the payments made for other Medicaid beneficiaries. California contends that the word "may" in this statute means that its obligation to cover cost-sharing for QMBs is permissive, rather than mandatory. None of the Four Circuits accepted this as a reasonable interpretation of Section 1396a(n).

In light of the mandatory nature of Sections 1396a(a)(10)(E)(i) and 1396d(p)(3), the contemporaneous legislative history, and the Medicare requirement that providers be reimbursed for 100% of their costs, the Four Circuits held that Section 1396a(n) had no impact on the requirement that states pay full cost-sharing for QMBs. Three of the four circuits reasoned that this statute allowed states to exceed their standard Medicaid rates for QMBs and allowed

providers to accept such higher payments.[10] Only the *Kozlowski* Court had a slightly different interpretation, finding that this statute allowed states to pay slightly more for pure QMBs than for dual eligibles. 42 F.3d at 1454. While the Hospitals concur with the prevailing view of the Second, Third and Eleventh Circuits, the significant fact is that *none* of the Four Circuits accepted the defendants' reading of Section 1396a(n) and that *all* of the Four Circuits *consistently* held that Section 1396a(n) could not reasonably be read to make a state's obligation to pay full cost-sharing discretionary.

Thus, the Ninth and Seventh Circuits' reasoning that the pre-BBA provisions were ambiguous regarding the states' cost-sharing obligation, which allowed them to defer to Section 4714's "clarification" and bypass the difficult constitutional questions which retroactive application raised, was not only unfounded, but also directly conflicts with the holdings of the Four Circuits. The Supreme Court should grant certiorari to resolve this conflict.

B. There Is A Conflict In This Court's Pronouncements Regarding The Deference Accorded To Congressional Enactments Which Purport To Clarify The Intent Of A Prior Congress.

The court below, and the *Paramount* court, resolved these cases by simply deferring to Congress' so-called "clarification" of the law expressed in Section 4714 of the BBA. Both courts felt

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10. The Ninth Circuit characterized the Second Circuit ("*Perales*") and the Third Circuit ("*Snider*") as having given different interpretations to Section 1396a(n). In fact, their interpretations were the same: *Perales* (954 F.2d at 860) found that the statute allowed states to exceed their Medicaid rates for QMBs, while *Snider* (29 F.3d at 895) found that the statute allowed providers to accept more than the Medicaid rates for QMBs; these are two sides of the same coin. *Haynes* (36 F.3d at 1076) directly followed the interpretation set forth in *Snider*.

constrained to grant such deference to Section 4714 because of a line of Supreme Court cases which have stated that legislation which expresses the intent of an earlier statute must be accorded great weight. *See, e.g., Loving v. United States*, 517 U.S. at __, 116 S. Ct. at 1749; *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381-82 & n.8, 89 S. Ct. 1794, 1801-02 & n.8, 23 L. Ed. 2d 371 (1969). Both courts erred in applying this line of cases because an objective examination of Section 4714 demonstrates that it is truly a change in existing law, rather than merely the expression of an earlier Congress' intent, regardless of the "clarification" label.

It is perhaps understandable that the courts erroneously applied this standard, since this Court's guidance on the appropriate weight given to legislation purporting to interpret earlier enacted statutes has been somewhat dichotomous. As Judge Posner stated in *Paramount*, this Court's inconsistent decisions on this issue have placed the lower courts in a quandary, and clarification by the Court on this issue would be extremely helpful. 138 F.3d at 711. Without such elucidation, and if the decisions below are allowed to stand, Congress will feel increasingly emboldened to retroactively nullify, in the guise of "clarifications," previous statutes which have exceeded budgetary expectations or which have been given judicial interpretations disfavored by a subsequent Congress.

This Court has made unequivocal statements that the opinions of a subsequent Congress on the meaning of legislation enacted by an earlier Congress should have little, if any, significance. *See e.g., South Dakota v. Yankton Sioux Tribe*, 118 S. Ct. 789, 803-04, 139 L. Ed. 2d 733 (1998); *Public Employees v. Betts*, 492 U.S. 158, 168, 109 S. Ct. 2854, 2862, 106 L. Ed. 2d 134 (1989) ("We have observed on more than one occasion that the interpretation given by one Congress . . . is of little assistance in discerning the meaning of [a prior] statute."); *United States v. Philadelphia National Bank*, 374 U.S. 321, 348-49, 83 S. Ct. 1715, 1733, 10 L. Ed. 2d 915 (1963) ("The views of a subsequent

Congress form a hazardous basis for inferring the intent of an earlier one."). On the other hand, this Court has also stated that subsequent congressional views are entitled to "great weight" in construing the meaning of earlier statutes. *Loving v. United States*, 517 U.S. at __, 116 S. Ct. at 1749; *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 118 n.13, 100 S. Ct. 2051, 2061 n.13, 64 L. Ed. 2d 766 (1980). (*See* additional cases espousing both of these conflicting propositions, cited in the Petition for Certiorari filed by the California Ambulance Association and the California Medical Association.)

The Ninth Circuit attempted to harmonize these conflicting lines of cases on the grounds that those cases which question the value of the later Congress' opinion on an earlier statute have all involved attempts to use less formal types of subsequent legislative history, rather than subsequent statutes, to infer the meaning of prior enactments. 132 F.3d at 1259. However, as Judge Posner noted in the *Paramount* decision, some of the cases in the *Philadelphia National Bank* line give little weight to subsequent *legislation* as a guide to interpreting the intent of an earlier Congress, 138 F.3d at 710-11; *see, e.g., Yankton*, 118 S. Ct. at 803; *Rainwater v. United States*, 356 U.S. 590, 593, 78 S. Ct. 946, 949, 2 L. Ed. 2d 996 (1958); *see also Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 839-40, 108 S. Ct. 2182, 2190-91, 100 L. Ed. 2d 836 (1988).

Having given short shrift to the line of cases which minimizes the value of later Congressional enactments to interpret earlier ones, the court below simply gave "great weight" to Section 4714 for determining the meaning of pre-existing law.[11] The *Paramount* court had much more difficulty with this exercise, only reluctantly giving credit to Congress' purported clarification in Section 4714:

11. In fact, the Ninth Circuit only looked at the impact of Section 4714 on Section 1396(a)(n). It ignored the statutes which are the foundation of the states' obligation to pay full Medicare cost-sharing: Sections 1396(a)(10)(E)(i) and 1396(d)(p)(3).

> So we're in a quandary concerning the continued vitality of the *Loving* line and would welcome clarification from the Supreme Court — pending which we feel constrained by *Loving* to give *some* weight to Congress's declaration in the Balanced Budget Act that providers of services to quimbies are not entitled to reimbursement at full Medicare rates.

138 F.3d at 711.

The Seventh Circuit further pointed out specific reasons why little, if any, weight should be given to the pronouncement of the 1997 Congress on the prior meaning of the law. In fact, the Seventh Circuit stated that there is "an air of unreality in treating section 4714(a) as an attempted clarification of original statutory meaning," pointing out that the disputed statutory provisions were enacted 11 years before the BBA was passed. 138 F.3d at 709-710. Not only is there little continuity between the members of the 1986 Congress and the 1997 Congress, the issue is so esoteric that even remaining members of Congress would undoubtedly have little memory of what the original statutory language could have meant. The existence of such purported "clarifications" by subsequent Congresses, and Section 4714 is by no means an isolated example,[12] is a compelling reason for this Court to explain *Loving*. Otherwise, Congress can twist the meaning of earlier statutes, regardless of the age of those provisions.

Deferring to Section 4714 is especially egregious because the statute itself clearly demonstrates that it represents a change in law,

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12. The BBA contained numerous purported "clarifications" of earlier legislation, a number of which directly appear aimed at reversing intervening court decisions in order to save federal dollars. (*See* more detailed discussion of these additional clarifications in the Petition for Certiorari filed by the California Ambulance Association and the California Medical Association.)

rather than a true clarification. Indeed, Section 4714 does not even modify the language of the original Section 1396(a)(n) to provide the "cap" on the states' obligation which purportedly was always contained within it. To the contrary, Section 4714 adds a completely new provision to achieve that result. The new provision, designated subsection 1396a(n)(2), provides that the states may pay less than the full Medicare cost-sharing for QMBs. The original provision was kept intact (and re-numbered as 1396a(n)(1)). If the original provision was not rendered surplusage by Section 4714, a construction disfavored by *Morton v. Mancari*, 417 U.S. 535, 551, 94 S. Ct. 2474, 2483, 41 L. Ed. 2d 290 (1974), and *United States v. Menasche*, 348 U.S. 528, 538-39, 75 S. Ct. 513, 519-20, 99 L. Ed. 615 (1955), it must therefore serve the purpose it always served, *i.e.*, to make clear that the states would not be violating their own Medicaid plans when making QMB payments at the higher Medicare rate.

Further, the new subsection a(n)(2) specifically allows states to limit their cost-sharing for QMBs to the Medicaid rate for Medicaid beneficiaries who are not Medicare beneficiaries. Nothing in the previous law authorized states specifically to cap their reimbursement at such a level. Additionally, the establishment of an "effective" date for the new law (August 5, 1997), and the "retroactive" application in certain limited situations (*i.e.*, pending or subsequently filed litigation), belies the concept of the statute as a "clarification." If the statute were truly a clarification, it would not become effective as of the present enactment date; it would merely be a statement of what the law always was.

In addition to the specific reasons why it is illogical to consider Section 4714 as a true clarification of prior law, the context of this enactment undercuts its consideration as a clarification. As Judge Posner pointed out:

> The location of the 1997 amendments in a statute labeled the "Balanced Budget Act" and concerned primarily with cutting the federal deficit hardly

> creates confidence that Congress was, court-like, interpreting the 1986 statute. It is far more realistic to regard the 1997 quimby provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government.

Paramount, 138 F.3d at 710.

The application of the *Loving* principle — giving deference, whether great or slight, to a statutory declaration regarding the meaning of prior law — is especially misguided here, when congressional action is so transparently an attempt to overturn the judicial construction of prior law. Certiorari should be granted so that this Court will have an opportunity to consider what strictures should be placed on Congress' ability to reinterpret existing laws.

II. THIS COURT SHOULD REVIEW THE CONSTITUTIONALITY OF BBA SECTION 4714(C) UNDER THE ARTICLE III SEPARATION OF POWERS DOCTRINE, TO CLARIFY THE SCOPE OF *UNITED STATES v. KLEIN*, 80 U.S. (13 WALL.) 128, 20 L. ED. 519 (1871), WHICH HAS BEEN CALLED INTO QUESTION BY THE COURT'S DECISIONS IN *ROBERTSON v. SEATTLE AUDUBON SOC'Y*, 503 U.S. 429, 441, 112 S. CT. 1407, 1414, 118 L. ED. 2D 73 (1992) AND *PLAUT v. SPENDTHRIFT FARM, INC.*, 514 U.S. 211, 115 S. CT. 1447, 1452 (1995).

Congress has given Section 4714 an effective date of August 5, 1997, but has commanded the courts to apply one of Section 4714's provisions retroactively to payments for health services provided before enactment. Congress has applied this amendment to pending litigation, without repealing or amending the old law. Moreover, the change is to Congress' and the states' fiscal advantage. Congress has compelled this particular reading of the

statutes here at issue in the face of the Four Circuits' decisions holding that the prior law clearly required a different result. Petitioners believe such legislation violates the separation of powers proscription in *United States v. Klein*. If it does not, very little remains of the *Klein* prong of the Separation of Powers Doctrine.

In *Klein*, this Court held that Congress may not prescribe rules of decision for the courts. *Klein* occurred in the wake of the Civil War when Congress enacted legislation giving former owners of property seized by the government, with proof of loyalty, the right of action to recover proceeds from the federal government's sale of their property. This Court held that a presidential pardon was sufficient proof of loyalty entitling its recipient to recover. *United States v. Padelford*, 76 U.S. (9 Wall.) 531, 542-43, 19 L. Ed. 788 (1869). In 1865, Klein filed a petition to collect the proceeds from the sale of cotton seized by the Union during the war. In 1868, the Court of Claims determined that a presidential pardon entitled the estate to recover the proceeds. Pending the government's appeal from that judgment to this Court, Congress enacted a statute providing that no presidential pardon should be admissible as proof of loyalty, that acceptance of such a pardon should be conclusive evidence of the claimant's disloyalty, and the Court of Claims and this Court must dismiss for want of jurisdiction any pending claims based on a presidential pardon. Act of July 12, 1870, ch. 251, 16 Stat. 235; *see Klein*, 80 U.S. (13 Wall.) at 132-34, 143-44. This Court declared the 1870 statute unconstitutional. The Court stated that Congress had exceeded its constitutional power to limit the Court's appellate jurisdiction:

> It is evident . . . that the denial of jurisdiction to this court, as well as to the Court of Claims, is founded solely on the application of a rule of decision, in causes pending, prescribed by Congress. The court has jurisdiction of the cause to a given point; but when it ascertains that a certain state of

> things exist, its jurisdiction is to cease and it is required to dismiss the cause for want of jurisdiction.
>
> It seems to us that this is not an exercise of the acknowledged power of Congress to make exceptions and prescribe regulations to the appellate power.
>
> . . . .
>
> Can [Congress] prescribe a rule in conformity with which the court must deny to itself the jurisdiction thus conferred, because and only because its decision, in accordance with settled law, must be adverse to the government and favorable to the suitor? The question seems to us to answer itself.

Klein, 80 U.S. (13 Wall.) at 146-47.[13]

Some noted legal commentators have found that *Klein* "is not a model of clarity." Paul M. Bator, Paul J. Mishkin, Daniel J. Meltzer & David L. Shapiro, *Hart & Wechsler's The Federal Courts and the Federal System* 369 (3d edition 1988). Even this Court has not uniformly described the *Klein* proscription against certain legislation. The Court has, on occasion, treated the decision narrowly, holding that Congress may not "attempt to prescribe to the judiciary the effect to be given to a [presidential] pardon, in regard to a matter in which the pardon extended." *Hart v. United States*, 118 U.S. 62, 6 S. Ct. 961, 963, 30 L. Ed. 96 (1886); *see Public Citizen v. United States Dep't of Justice*, 491 U.S. 440, 485, 109 S. Ct. 2558, 2582-83, 105 L. Ed. 2d 377 (1989) (Kennedy, J., concurring in the judgment). *Klein* also has been described as holding that Congress may not "attempt to invade the

13. Secondarily, the court found that the rule of decision at issue, which impaired the effect of a pardon, also impermissibly infringed on the constitutional power of the executive. *Id.* at 147.

judicial province by prescribing a rule of decision in a pending case." *Glidden Co. v. Zdanok*, 370 U.S. 530, 568, 82 S. Ct. 1459, 1482, 8 L. Ed. 2d 671 (1962) (plurality opinion).

In 1980, this Court read *Klein* as an amalgam of these rationales: Congress may not "prescribe . . . a rule of decision in a case pending before the courts, . . . in a manner that required the courts to decide a controversy in the Government's favor." *United States v. Sioux Nation*, 448 U.S. 371, 404, 100 S. Ct. 2716, 2735-36, 65 L. Ed. 2d 844 (1980). The Court found "of obvious importance" to the *Klein* holding, that "Congress was attempting to decide the controversy in [its] own favor." 448 U.S. at 405, 100 S. Ct. at 273. Thus, Congress' action was not grounded in any broad power conferred on it by the Constitution. *Id. Sioux Nation* was perhaps this Court's most complete description of the meaning of the proscription in *Klein*. Unfortunately, the Court's next two opportunities to address the *Klein* prong of the separation of powers doctrine have created some confusion.

In *Seattle Audubon Soc'y v. Robertson*, 914 F.2d 1311 (9th Cir. 1990), *rev'd*, 503 U.S. 429 (1992) the Ninth Circuit had an opportunity to review this Court's separation of powers jurisprudence, including *Klein* and its progeny. In that case, the Ninth Circuit, and subsequently this Court, considered the constitutionality of Section 318 of the Department of the Interior and Related Agencies Appropriations Act of 1990, Pub. L. 101-121, § 318, 103 Stat. 745-50 (1989). In Section 318(b)(6)(A), Congress:

> Determine[d] and direct[ed] that management of areas according to subsections (b)(3) and (b)(5) of this section on the thirteen national forests in Oregon and Washington and [BLM] lands in western Oregon known to contain northern spotted owls *is adequate consideration for the purpose of meeting the*

> *statutory requirements that are the basis for [various federal court actions].* (Emphasis added.)[14]

The Ninth Circuit found that Section 318 "directs the court to reach a specific result and make certain factual findings under existing law in connection with . . . cases pending in federal court" contrary to the Supreme Court's holding in *Klein*, 914 F.2d at 1316.

This Court reviewed the Ninth Circuit's *Seattle Audubon* decision and overturned it. 503 U.S. 429, 112 S. Ct. 1407, 118 L. Ed. 2d 73 (1992). The linchpin of the Court's decision was whether the statutory provision in question "compelled changes in law, not findings or results under old law." 503 U.S. at 438, 112 S. Ct. at 1413. The Court held:

> We have no occasion to address any broad question of Article III jurisprudence. The Court of Appeals held that subsection (b)(6)(A) was unconstitutional under *Klein* because it directed decisions in pending cases without amending any law. Because we conclude that subsection (b)(6)(A) did amend applicable law, we need not consider whether this reading of *Klein* is correct.[15]

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14. That section

> sets terms and conditions applicable only for fiscal year 1990 for making timber sales on federal lands in Oregon and Washington, for managing habitat for northern spotted owls, and minimizing fragmentation of significant old-growth forests stands.

H.R. Conf. Rep. No. 101-264, 101st Cong., 1st Sess. 87 (1989).

15. In reviewing the statutory change, the Court noted:

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503 U.S. at 441, 112 S. Ct. at 1414. The Court recognized a prospective temporary suspension of the law as a repeal or amendment that satisfied some of the *Klein* Court's concerns under Article III. At the same time, the Court called into question whether, even if the Ninth Circuit had correctly characterized Section 318, a *Klein* constitutional violation by Congress would be found by this Court. *Id.*

Five years later, in *Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 115 S. Ct. 1447, 131 L. Ed. 2d 328 (1995), the Court had occasion to consider the constitutionality of Congress' decision to reopen final judicial decisions. In the course of finding such a provision unconstitutional, the Court questioned the scope of *Klein*:

> Our decisions to date have identified two types of legislation that require federal courts to exercise the judicial power in a manner that Article III forbids. It first appears in *United States v. Klein* . . . , where we refused to give effect to a statute that was said "[t]o prescribe rules of decision to the judicial department

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> Before [the] subsection . . . was enacted, the original claims would fail only if the challenged harvesting violated none of five old provisions. Under [the] subsection . . . by contrast, those claims would fail if the harvesting violated neither of these two new provisions. Its operation, we think, modified the old provisions. Moreover, we find nothing in [the] subsection . . . that purported to direct any particular findings of fact or applications of law, old or new, to fact. For challenges to sales offered before and after fiscal year 1990, [the] subsection expressly reserved judgment upon "the legal and factual adequacy" of the administrative documents authorizing the sales. For challenges to sales offered during fiscal year 1990, subsection (g)(1) expressly provided for judicial determination of the lawfulness of those sales.
>
> 503 U.S. at 438-39, 112 S. Ct. at 1413.

> of the government in cases pending before it." *Id.* at 146. Whatever the precise scope of *Klein*, however, later decisions have made clear that its prohibition does not take hold when Congress "amend[s] applicable law." *Robertson v. Seattle Audubon Soc'y*, 503 U.S. 429, 441, 112 S.Ct. 1407, 1414, 118 L.Ed.2d 73 (1992).

514 U.S. at 218, 112 S. Ct. at 1452.

These cases presented the Court with the opportunity to provide direction to the lower courts by clarifying the scope of *Klein*.[16] The legislation here at issue clearly did not change the existing law as to services provided before enactment. Indeed, under Section 4717(c), Congress' reading of the old law applies only in states where litigation is filed, and only as to those providers who have initiated litigation. As to other states, the executive branch of the federal government, and those providers who do not file a lawsuit, Congress' reading of the old law does not apply to services provided before the date of enactment. The legislation here at issue is easily distinguishable from *Seattle Audubon Soc'y*, where Congress directed a prospective and time-limited change in the law, without directing an outcome as to litigation under previous statutory standards, or even standards that would be reinstated after the legislation sunsets. Instead, here, Congress did precisely what *Klein* prohibits. It did not repeal or otherwise amend the prior law with respect to nonlitigants or the executive branch; it simply directed that as to litigants the law meant a particular thing. Under Article III, that is the province of the courts and not Congress.

The additional element that concerned the *Klein* and *Sioux Nation* Courts is also present here. Congress is not acting to further

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16. The Ninth Circuit went to extreme lengths to avoid addressing these constitutional issues. Judge Posner, in *Paramount*, ruminated on the *Klein* type of separation of powers problem involved in this case, without ever resolving the issue. 138 F.3d at 710.

one of its constitutionally imposed responsibilities. Rather, it is acting to benefit the government in a dispute that would otherwise not be decided in its favor.

If the Court allows this naked exercise by the Congress of the judicial function to stand, we will have lost a significant check on overreaching conduct by the coordinate branches of government. The need to distribute and apportion the activities of government goes to the very structure of the Constitution. James Madison warned that "the accumulation of all powers . . . in the same hands, whether of one, a few, or many . . . may justly be pronounced the very definition of tyranny." The Federalist No. 47, at 322. That is precisely the kind of concern this Court addressed in *Klein* by refusing to allow Congress to manipulate the outcome of litigation to the government's advantage.

Given the lower courts' confusion regarding the reach of *Klein's* constitutional proscription, and Congressional interference with a judicial function through appropriations legislation that changes of the terms of Congress' bargain with an entire industry, review by this Court is warranted.

III. BY DEFERRING TO THE CONGRESSIONAL "CLARIFICATION", THE NINTH CIRCUIT IGNORED THE CONSTITUTIONAL TAKING PROBLEM WHICH WILL RESULT IN THE DISENTITLEMENT OF PROVIDERS TO FUNDS TO WHICH THEY WERE ENTITLED UNDER THE PRE-ENACTMENT STATUTES.

The Ninth Circuit's opinion below barely acknowledged, and did not address, the serious Constitutional takings issue raised by Congress' effort to label Section 4714 as a "clarification" of prior law. Instead of considering the existence of this issue as a factor which might militate against judicial deference to the legislature,

the court below found that it must "honor Congress' 'clarification' label . . . [which] moots all of appellees' constitutional objections to the new legislation." 132 F.3d at 1266. In so doing, the Ninth Circuit ignored a recently-affirmed line of this Court's decisions invalidating efforts by Congress to repudiate the contractual obligations of the United States.

This Court recently reiterated that government may not retroactively reduce or eliminate its own debts to save money. *See United States v. Winstar Corp.*, 518 U.S. 839, __, 116 S. Ct. 2432, 2459-60 and n.28, 2464-65 and n.39, 2468-69 n.51 (plurality opinion), 2475-76 (Breyer, J. concurring), 2478-79 (Scalia, J. concurring, joined by Kennedy, J. and Thomas, J.), 135 L. Ed. 2d 964 (1996). This Court found that the most protectable of government contracts with private parties are those in procurement or related situations. 518 U.S. at __, 116 S. Ct. at 2457. All four opinions in that case recognized such rights as protected against retroactive abrogation by the sovereign, relying on this Court's uncontroverted decisions in *Lynch v. United States*, 292 U.S. 571, 54 S. Ct. 840, 78 L. Ed. 1434 (1934) and *Perry v. United States*, 294 U.S. 330, 55 S. Ct. 432, 79 L. Ed. 912 (1935) ("the two principal cases of this century holding that the government may not simply repudiate its contractual obligations"). 518 U.S. at __, 116 S. Ct. at 2479. Both *Lynch* and *Perry* make clear that congressional abrogation of the "essential bargain" of a contract is an "impermissible repudiation." *Id*; *see Perry*, 294 U.S. at 350-354, 55 S. Ct. at 434-437; *Lynch*, 292 U.S. at 578-580, 54 S. Ct. at 843-844.

Here, the United States and California seek to avoid, through Section 4714, contractual rights even more worthy of protection than the prospective insurance benefits at issue in *Lynch*. *See* 292 U.S. at 580-81, 54 S. Ct. at 843-844. In this case, the medical services already have been provided, as even Congress recognized. BBA § 4714(c) (amendments "shall also apply to payment by a

State for items and services furnished before" the date of enactment if the subject of a lawsuit).

The law existing when the Hospitals provided services, 42 U.S.C. §§ 1396a(a)(10)(E)(i) and 1396d(p)(3), required payment to the Hospitals at the Medicare rate — including Part A cost-sharing from state and federal Medicaid funds. The Hospitals' rights to payment were vested.[17] An implied contract arises after services are rendered under a law specifying compensation to be paid at the amount fixed. *See Robertson v. Miller*, 276 U.S. 174, 179, 48 S. Ct. 266, 268, 72 L. Ed. 517 (1928).

The present deprivation is more direct, more immediate and less justifiable than the taking in either *Lynch* or *Perry*. Congress and California are walking away from debts to providers that were induced to provide hospital services to QMBs. The benefit that the United States will derive from retroactive application of Section 4714 cannot be overlooked. "[I]t makes sense to scrutinize governmental action more closely when the State stands to benefit."

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17. In describing this contractual relationship and the function of the Medicare Provider Agreements that form a part of it, the courts have explained that

> (t)he Provider agreement is a *unique type of contract*. It does not provide for a defined transaction or even a series of transactions. It . . . establishes a relationship between the parties: if [the provider] treats eligible patients, HHS will reimburse them for their costs.

University Medical Center v. Sullivan, 973 F.2d 1065, 1081 (3d Cir. 1992) (emphasis added). In effect, the Medicare Provider Agreement is deemed an "executory contract" between the provider and the government. *Id.* at 1076-1077; *see also California Medical Ass'n v. Lackner*, 117 Cal. App. 3d 552, 556-61, 172 Cal. Rptr. 815, 818-21 (1981) (Medicaid program regulations "amount to an offer which, when accepted by performance, culminates in a contract between the government and the offeree").

Harmelin v. Michigan, 501 U.S. 957, 978 n.9, 111 S. Ct. 2680, 2693 n.9, 115 L. Ed. 2d 836 (1991) (citing *Perry*, 294 U.S. at 350-51, 55 S. Ct. at 435). The United States will avoid the obligation to pay matching funds to the states through the effectof Section 4714, as Exhibit F indicates.

The Ninth Circuit's failure to address these Constitutional concerns elevates deference to a purported Congressional clarification above Petitioners' vested property interests. Certiorari should be granted to establish the vitality of *Lynch* and *Perry* in these circumstances.

CONCLUSION

For the foregoing reasons, the writ of certiorari should issue to review the judgment of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

JOHN R. HELLOW
Counsel of Record
BYRON J. GROSS
HOOPER, LUNDY & BOOKMAN, INC.
Attorneys for Petitioners
1875 Century Park East
Suite 1600
Los Angeles, CA 90067
(310) 551-8111

Dated: June 1, 1998

APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT FILED DECEMBER 2, 1997

FOR PUBLICATION

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, a California non-profit public benefit corporation, d/b/a BEVERLY HOSPITAL; BELLWOOD MEDICAL CORPORATION, d/b/a BELLWOOD GENERAL HOSPITAL; CHICO COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a CHICO COMMUNITY REHABILITATION HOSPITAL, d/b/a CHICO COMMUNITY HOSPITAL; HOLLYWOOD COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF VAN NUYS, d/b/a HOLLYWOOD COMMUNITY HOSPITAL OF HOLLYWOOD; LANCASTER HOSPITAL CORPORATION, d/b/a LANCASTER COMMUNITY HOSPITAL, et al.,

Plaintiffs-Appellees,

v.

KIMBERLY BELSHE, Director of the California Department of Health Services,

Defendant-Appellant.

No. 96-55208

D.C. No. CV-95-04053-JSL

OPINION

Appendix A

CALIFORNIA AMBULANCE ASSOCIATION, *Plaintiff-Appellee,* v. DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services, *Defendant,* and KIMBERLY BELSHE, Director of the California Department of Health Services, *Defendant-Appellant.*	No. 96-56249 D.C. No. CV-96-02322-JSL
CALIFORNIA AMBULANCE ASSOCIATION, *Plaintiff-Appellee,* v. DONNA E. SHALALA, Secretary of United States Department of Health and Human Services, *Defendant-Appellant.*	No. 96-56485 D.C. No. CV-96-2322-JSL

Appendix A

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants-Appellants.

No. 96-56648

D.C. No. CV-03033-JSL

Appendix A

RICHARD GILMORE, M.D.; SARAF PROTAP, M.D., *Plaintiffs-Appellees,* v. DONNA E. SHALALA, Secretary of the United States Department of Health and Human Resources, *Defendant,* S. KIMBERLY BELSHE, Director of Health Services, *Defendant-Appellant.*	No. 96-56699 D.C. No. CV-96-05564-JSL
RICHARD GILMORE, M.D., individually and on behalf of all those similarly situated; PRATAP SARAF, M.D., individually and on behalf of all those similarly situated, *Plaintiffs-Appellees,* v. DONNA E. SHALALA, Ph.D., Secretary of the United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services, *Defendants-Appellants.*	Nos. 96-56745 97-55220 D.C. No. CV-96-05564-JSL

Appendix A

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY, *Plaintiffs-Appellees,* v. DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services, *Defendant-Appellant.*	No. 97-55022 D.C. No. CV-96-03033-JSL
DONALD R. MACPHERSON, JR., as Successor in interest to decedent Christina MacPherson & MacPherson Oil Company Employee Welfare Benefit Plan, *Plaintiff-Appellant,* v. EMPLOYERS HEALTH INSURANCE, *Defendant-Appellee.*	No. 97-55713 D.C. No. CV-97-00514-JSL

Appendix A

Appeal from the United States District Court
for the Central District of California
J. Spencer Letts, District Judge, Presiding

Argued and Submitted
October 6, 1997—Pasadena, California

Filed December 2, 1997

Before: Stephen Reinhardt and A. Wallace Tashima,
Circuit Judges, and Milton I. Shadur, District Judge.*

Opinion by Judge Shadur

SUMMARY

Health/Medicaid/MediCare and Government Assistance

The court of appeals reversed judgments of the district court. The court held that amendments to the Medicare Act in the Balanced Budget Act of 1997 allows a participating state to limit beneficiary enrollment payments under the Medicare Act's cost-sharing provision to the amount by which the state's Medicaid rate exceeds what Medicare has paid.

In § 1396a(n) of the Medicare Act, Congress dealt with persons who are eligible for both Medicare (federal health insurance program for elderly and disabled) and Medicaid (cooperative federal-state program providing matching funds to states that elect to provide medical services to needy persons). Section 1396a(n) describes what the state plans can set up to cover their obligations on behalf of qualified medical beneficiaries (QMBs).

*The Honorable Milton I. Shadur, United States District Judge for the Northern District of Illinois, sitting by designation.

Appendix A

Appellant Secretary of the Department Health and Human Services took the legal position that under § 1396a(n), participating states have the choice to limit their cost-sharing payments for enrollment of QMBs to the amount by which the state's Medicaid rate exceeds what Medicare has paid. This is the interpretation under which California adopted "Medi-Cal," its Medicaid plan.

In a number of federal lawsuits, appellee Beverly Community Hospital Association and other Medicare and Medicaid providers challenged the reading of § 1396a(n) given by the Secretary and appellee Director of the California Department of Health Services. In each case, the district court rejected the Secretary's interpretation that under § 1396a(n), participating states have the choice to limit their payments so that they need not pay the full cost-sharing amount.

While the cases were pending on appeal, Congress passed the Balanced Budget Act of 1997 (BBA). Included in the statute as Act 4714 is a provision that expressly amends § 1396a(n) to adopt the Secretary's position, and expressly applies to pre-enactment state payments that were the subject of litigation pending on the date of enactment. Congress captioned the new provision a "clarification" regarding state liability for Medicare cost-sharing.

The central issue on appeal was whether the BBA requires application of the Secretary's interpretation of the pre-enactment version of the Medicare statute.

[1] It did not matter whether congressional labeling of the new legislation as a "clarification" had to be credited by a court. What was significant was that Congress's characterization reflected its intention to resolve every still-live dispute in the manner specified. The statutory reference to "pending" lawsuits had to be construed as embracing cases undecided at the district court level and actions pending on appeal.

[2] Because Congress has the authority to change the law as to pending cases, its power to clarify the law—to confirm what the law has always meant—follows a fortiori. [3] If Act 4714 were to be characterized as a substantial change in the law, its retroactive application would have posed potential constitutional problems. If it merely clarified what § 1396a(n) was intended to mean, the Medicaid Act never required states to pay cost-sharing in full.

[4] Congress expressly stated as its intention that the new provision in Act 4714 was a "clarification" of the payment rules contained in § 1396a(n). Congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight.

[5] The argument, that § 4714 effected such a substantial change in terms of the government's liability to health care providers that it could not be treated as clarifying § 1396a(n), proceeded from the premise that § 1396a(n)'s meaning was clear enough so as to need no further explanation. That premise ignored the split of authority construing the statute. Clarity is absent from the Medicare and Medicaid statutes.

[6] Section 1396a(n) was particularly resistant to a single interpretation, and particularly in need of clarification. [7] Given the difficulty that courts have had in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of § 1396a(n) was worthy of real deference.

[8] Act 4714's provisions are a statement of what § 1396a(n) meant all along. That mooted all constitutional objections to the new legislation because they rested on the assertedly retroactive nature of Act 4714.

[9] Any claim that California was violating the new federal statute represented the basis for a new lawsuit. Any such claim called for the generation of a new record, against which

the trial court could determine whether there was anything to the contention that Act 4714's clarification of prior law somehow rendered invalid the Medi-Cal reimbursement methodology for hospitals. The trial court would also have to determine whether that argument might have been forfeited by not raising it the first time around.

COUNSEL

Beverly v. Belshe

Laurie R. Pearlman, California Attorney General, Los Angeles, California, for the defendant-appellant.

John R. Hellow and Kevin M. Corbett, Hooper, Lundy & Bookman, Inc., Los Angeles, California, for the plaintiffs-appellees.

Alissa B. Klein, United States Department of Justice, Civil Division, Washington, D.C.; Sanford E. Pitler, Bennett & Bigelow, D.S., Seattle, Washington, for the amicus.

CAA v. Belshe and Shalala

Charlton G. Holland III and Ralph Johnson, California Attorney General, San Francisco, California; Alissa B. Klein, United States Department of Justice, Civil Division, Washington, D.C., for the defendants-appellants.

William J. Bush, Hanson, Bridgett, Marcus, Vlahos & Rudy, LLP, San Francisco, California, for the plaintiffs-appellees.

Gilmore v. Belshe and Shalala

Charlton G. Holland III and Ralph Johnson, California Attorney General, San Francisco, California; Alissa B. Klein,

Appendix A

United States Department of Justice, Civil Division, Washington, D.C., for the defendants-appellants.

Michael A. Greene, Greenburg, Glusker, Fields, Claman & Machtinger LLP, Los Angeles, California; Bruce S. Sperling, Sperling, Slater & Spitz, P.C., Chicago, Illinois; Harvey J. Barnett, Harvey J. Barnett & Associates, P.C., Chicago, Illinois, for the plaintiff-appellee.

OPINION

SHADUR, District Judge:

We address here a question of first impression, not only in this Circuit but (understandably in light of the recency of the legislation involved) in any court: whether a congressional enactment adopted in August 1997, but stating that it is retroactive and applicable to pending cases, calls for approval of the reading that has been given to the pre-enactment version of the same legislation by the Secretary of the United States Department of Health and Human Services ("Secretary"). Because we answer that question in the affirmative, we reverse all three decisions below.[1]

All three of these sets of appeals pose a common problem: whether the State of California may choose to limit certain payments, as required by statute to be made to enroll poor people—qualified Medicare beneficiaries ("QMBs")—in the Medicare insurance program, to the amount by which California's Medicaid rate exceeds what Medicare has paid. Those payments, required from all participating states under the Medicaid Act, extend to deductibles, coinsurance and copayments that the QMBs cannot bear fully and that the State is

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[1] In each instance the jurisdiction of the district court was based upon 28 U.S.C. §1331. All three judgments are appealable pursuant to 28 U.S.C. §1291.

required to pay on their behalf (whether totally or in part is at stake in these cases).

Title XVIII of the Social Security Act (the "Medicare Act," 42 U.S.C. §§1395-1395ccc[2]) provides a federal health insurance program for elderly and disabled persons. Medicare Part A covers inpatient hospital services and certain related benefits (Sections 1395c-1395i-4), and it is provided automatically for individuals entitled to Social Security retirement or disability benefits (Section 426). Medicare Part B is a voluntary program under which Medicare-eligible persons can obtain supplemental insurance for various outpatient services from physicians and other providers (Sections 1395j-1395w-4). It is financed by a combination of federal funds and premiums paid by or on behalf of eligible individuals (Sections 1395r, 1395t(g)). Both Medicare Part A and Medicare Part B call for payments by covered individuals that constitute the deductibles, coinsurance and copayments referred to earlier.

Title XIX of the Social Security Act (the "Medicaid Act," Sections 1396-1396v) is a cooperative federal-state program that provides federal matching funds to states that elect to provide medical services to certain needy individuals (see Section 1396; *Harris v. McRae*, 448 U.S. 297, 301 (1980)). Although states are not required to participate in Medicaid, if they elect to do so they must follow federal guidelines (*Harris*, 448 U.S. at 301) and must submit for Secretary's approval their state plans that describe the states' intended means for insuring compliance with those guidelines (Section 1396a(b)).

What is at issue in these three sets of appeals is the area of overlap between the Medicare and Medicaid Acts where coverage for the elderly poor is involved. Those persons are often

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[2]All further citations to Title 42 provisions will take the form "Section —," utilizing the Title 42 numbering system rather than the internal numbering of the Acts involved.

entitled to participate in such coverage but may not be able to afford to pay the required deductible and coinsurance amounts under Medicare Part A or the premiums and payments needed to enroll in Medicare Part B. At the time that the various lawsuits were filed below, Congress had dealt with individuals who are eligible for both Medicare and Medicaid (see Section 1396d(p)(1)) by stating in Section 1396a(n) of the Medicaid Act what the state plans could set up to cover their obligations on behalf of the QMBs involved.

Three types of plaintiffs (now appellees) are involved in these appeals. *Beverly Hospital* is a class action on behalf of all California hospitals that provide inpatient hospital services under the Medicare and Medicaid Acts. *California Ambulance* involves two types of associations, California Ambulance Association and physician associations including California Medical Association, each type of association also representing providers of services under the two statutes. And *Gilmore* was brought by two doctors who provide outpatient physician services to persons under the two statutes.[3] Thus *Beverly Hospital* involves Medicare Part A, while *California Ambulance* and *Gilmore* implicate Medicare Part B.

Secretary is an appellant in all of the cases except for *Beverly Hospital*, in which she was given leave to participate as an amicus curiae. Director S. Kimberly Belshe of the California Department of Health Services ("Director") is an appellant in all of the cases. Both appellants subscribe to Secretary's legal position pursuant to which California adopted its Medicaid state plan ("Medi-Cal"), which position asserts that under Section 1396a(n) participating States such as California have the choice to limit their payments as described earlier, so that they need not pay the *full* cost-

[3]Although the *Gilmore* case was originally intended to be a class action, any need for class certification was obviated when defendants agreed that the result in the case would be followed as to all persons providing such services.

sharing amount. In each of the cases before us the District Court rejected that contention, as have all four Courts of Appeals that have addressed the question: *Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444 (4th Cir. 1994)("*Kozlowski*"); *Haynes Ambulance Serv., Inc. v. State of Alabama*, 36 F.3d 1074 (11th Cir. 1994)("*Haynes*"); *Pennsylvania Med. Soc'y v. Snider*, 29 F.3d 886 (3d Cir. 1994)("*Snider*"); and *New York City Health and Hosps. Corp. v. Perales*, 954 F.2d 854 (2d Cir. 1992)("*Perales*").[4]

After the scheduled briefing of these appeals had been completed, Congress entered the picture. Its Balanced Budget Act of 1997 ("Act"), signed into law by the President on August 5 of this year, included as Act §4714 a provision that expressly amends Section 1396a(n) to adopt the position advanced by Secretary and Director here:

> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.
>
> (3) In the case in which a State's payment for

[4]Although this does not affect our resolution of these cases in light of what follows, it is worth noting that those four Courts of Appeals have employed divergent approaches (reading the statute differently) in reaching their conclusions. And it may be added that those four decisions (and the decisions now on appeal) do not at all reflect a unanimous judicial reaction: For example, two recent District Court decisions, *Dameron Physicians Med. Group v. Shalala*, 961 F.Supp. 1326 (N.D. Cal. 1997) and *Kulkarni v. Leean*, No. 96 C 884-S, 1997 WL 527674 (W.D. Wis. June 23), have joined other lower court decisions going the other way. See also the discussion of the problem at 66 U.S.L.W. 2233 (Oct. 21, 1997).

medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

> (A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;
>
> (B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and
>
> (C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.
>
> This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

There is no dispute among the litigants that if this new statutory provision (which Congress has captioned "Clarification Regarding State Liability for Medicare Cost-Sharing") is applicable, it requires the reversal of the District Court's decisions. One minor variant exists: Beverly Hospital contends that a remand is necessary because Secretary's methodology,

as applied to that hospital's situation, does not mesh with the new enactment. We speak briefly to that question later.

Because Congress was deliberately targeting what were known to be existing disputes on this subject, Act §4714(c) went on to prescribe a retroactive effective date of the quoted amendment:

> (c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act[5] and that is pending as of, or is initiated after, the date of the enactment of this Act.

That being the case, the relevant considerations in our three cases have shifted from those that had occupied the parties' entire scheduled briefing, which (as stated earlier) had been completed before the congressional enactment. We therefore invited and received supplemental briefing on the effect of Act §4714 on these cases. And having done so, we eschew any analysis of those original arguments and turn instead to the validity and applicability of the August 1997 enactment.

Standard of Review

Both because constitutional questions are at issue and

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[5]Those cited sections of the Social Security Act respectively correspond to Sections 1396a(n) and 1396(d) in the Title 42 usage employed in this opinion. Those sections are in fact the statutory provisions involved in these appeals.

because the cases come up on summary judgment, we engage in a de novo review of the district courts' final judgments (*Gray v. First Winthrop Corp.*, 989 F.2d 1564, 1567 (9th Cir. 1993) ("The constitutionality of a statute is a question of law which we review de novo"); *Brinson v. Linda Rose Joint Venture*, 53 F.3d 1044, 1047 (9th Cir. 1995) (holding that an order granting summary judgment is reviewed de novo)). Each of the issues before us will be examined through that lens.

Application of Act §4714

[1] At the outset we examine the coverage of these appeals by the new legislation—a matter that was challenged in the appellees' briefs but was not addressed by their counsel during oral argument. As the earlier-quoted Act §4714(c) states, the new amendments apply to any payments by a State for items and services furnished pre-enactment as long as the payment "is the subject of a lawsuit...that is pending as of... the date of the enactment of this Act." In that respect it does not matter whether the congressional labeling of the new legislation as simply a "clarification" has to be credited by a court (a subject that we deal with in a moment). What is instead significant is that Congress' characterization plainly reflects its intention to resolve every still-live dispute in the manner specified by the new legislation. Hence the statutory reference to "pending" lawsuits must be construed as embracing not only undecided cases at the District Court level but also actions pending on appeal, such as the ones before us.

[2] We have previously ascribed precisely that meaning to the term "pending" in *Gray*, 989 F.2d at 1571. There we cited and quoted from numerous earlier decisions upholding Congress' power to impact the results in cases still "pending" on appeal without running afoul of separation of powers principles:

> These cases are properly construed as "pending" cases for separation of powers purposes. *See Griffith*

> *v. Kentucky*, 479 U.S. 314, 321 n.6, 107 S.Ct. 708, 712 n.6, 93 L.Ed.2d 649 (1987)(judgment is "final" and case is no longer pending only after "the availability of appeal [is] exhausted, and the time for a petition for certiorari [has] elapsed or a petition for certiorari finally [has been] denied"); *see also Georgia Ass'n of Retarded Citizens v. McDaniel*, 855 F.2d 805, 813 (11th Cir. 1988)("When it so intends, [Congress'] ability to affect the content of a nonfinal judgment in a civil case, through retroactive legislation ceases only when a case's journey through the courts comes to an end."), *cert. denied*, 490 U.S. 1090, 109 S.Ct. 2431, 104 L.Ed.2d 988 (1989); *de Rodulfa v. United States*, 461 F.2d 1240, 1253 (D.C. Cir.)("[T]he suit is pending until the appeal is disposed of, and until disposition any judgment appealed from it is still *sub judice*.") (internal quotations omitted), *cert. denied*, 409 U.S. 949, 93 S.Ct. 270, 34 L.Ed.2d 220 (1972).

And what *Gray*, *id.* then said, albeit in the different context of a change in a statute of limitations, applies with equal force to give identical content to the word "pending" in Act §4714(c):

> Because none of the cases here have completed their journey through the appellate process, Congress has the authority to change the underlying substantive law by altering the statute of limitations in a way that affects those pending cases.

Because Congress thus has such authority to *change* the law as to pending cases, its power to *clarify* the law—to confirm what the law has always meant—follows a fortiori.

[3] That being the case, the next line of inquiry is whether the new enactment is valid in its application to such pending cases. On that score a key threshold issue is whether the

enactment was truly a "clarification" of the prior statute (as Congress said), or was instead a substantial change in the law. If Act §4714 were to be characterized in the latter fashion, its retroactive application would pose a series of potential constitutional problems. If however Act §4714 merely clarifies what Section 1396a(n) was originally intended to mean, then the Medicaid Act never required states such as California to pay cost-sharing in full. In that event the only function of Act §4714 in this situation is to state more clearly what the law already was—it has no retroactive effect that might be called into constitutional question. Because appellees do not dispute the constitutionality of the prospective application of Act §4714, if that provision merely clarifies Section 1396a(n) there are also no potential constitutional problems with the application of the enactment to these pre-Act cases.

[4] As already indicated, Congress expressly (and formally) stated as its intention that the new provision in Act §4714 was a "clarification" of the payment rules contained in Section 1396a(n). It has been established law since nearly the beginning of the republic (as demonstrated by *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 380-81 & n.8 (1969) and earlier cases cited there) that congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight (see most recently *Loving v. United States*, 116 S. Ct. 1737, 1749 (1996), quoting the *Red Lion* language as earlier repeated in *Consumer Product Safety Comm'n v. GTE Sylvania*, 447 U.S. 102, 118 n.13 (1980); and see also the plurality opinion in *United States v. Winstar Corp.*, 116 U.S. 2432, 2463 (1996)(speaking in terms of "significant weight")).

Other cases that question the competence of a later Congress to opine on the intended meaning of an earlier statute are readily distinguishable. All of those cases have involved attempts to use less formal types of subsequent legislative history, particularly Senate and House Committee Reports, to infer the meaning of prior enactments (*United States v. South-*

western Cable Co., 392 U.S. 157, 170 (1967), rejecting the use of congressional opinions contained solely in House Committee Reports; *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979), rejecting the use of congressional opinions expressed only in Senate Report; and see *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 839-40 (1988), rejecting the use not only of a later House Committee Report but also of the later enactment as such as bases for inferring the intent of an earlier Congress). By contrast, here Congress has formally declared Act §4714 to be a clarification of Section 1396a(n) in the title of the Act as well as in the Committee Reports.[6] Such formal legislative action squarely fits the *Red Lion* mold as so often (and so recently) reconfirmed by later cases, so that Act §4714 is entitled to great weight in construing the meaning of Section 1396a(n).

[5] Appellees contend that Act §4714 effected such a substantial change in federal law in terms of the government's liability to health care providers that it cannot be treated as simply clarifying Section 1396a(n). But that argument proceeds from the premise that Section 1396a(n)'s meaning was clear enough so as to need no further explanation. Not only does that premise ignore the split of authority construing the statute (though to be sure the four Court of Appeals opinions have uniformly rejected Secretary's reading), but even more significantly any quality of crystal clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes (thus even one of the cases relied on by appellees, *Kozlowski*, 42 F.3d at 1450, has pungently—and accurately—characterized the provisions detailing Medicaid and Medicare

[6]While titles of acts are not part of the law, they can be used to resolve ambiguity in a statute, so long as they do not contradict the actual test (see, e.g., *INS v. National Ctr. for Immigrants' Rights, Inc.*, 502 U.S. 183, 189 (1991) and cases cited there). In this instance the congressional title, rather than merely resolving an ambiguity, parallels the provision in Act §4714(c) that specifically makes the statute applicable to pre-Act services involved in pending litigation.

financing as "among the most completely impenetrable texts within human experience").

[6] Section 1396a(n) is a superb example of the baffling nature of the statute. It has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification. While one battle has raged (with mixed results) over whether to accept Secretary's construction of the provision, even the courts that have rejected Secretary's approach have not expressed a single construction of the statute (compare *Kozlowski*, 42 F.3d at 1454, reading Section 1396a(n) to allow a state to exercise the option to pay more for a QMB than for a dual-eligible person; *Perales*, 954 F.2d at 859, stating "it appears that the reason that section a(n) authorizes payment beyond the Medicare amount, when it is required by another section, is to clarify that the Medicaid Act does not prohibit a provider from accepting more than the Medicaid rate"; and *Snider*, 29 F.3d at 895, holding that Section 1396a(n) "authorizes the states to deviate from their schedules or payment methods with respect to QMB Part B cost-sharing payments, thus carving out an exception to the general requirement to comply with the Medicaid fee schedules or payment methods"). Only *Haynes*, 36 F.3d at 1076, by following the interpretation established in *Snider*, avoids the spectre of four Courts of Appeals reaching the same result for four (rather than three) different reasons. Congress noted the existing confusion when it made the statement (really an understatement) that the amount that states were required to pay on behalf of QMBs was "the subject of some controversy" (H. Conf. Rep. No. 105-217, 143 Cong. Rec. H6252 (daily ed. July 29, 1997)).

[7] Given the extraordinary difficulty that the courts have found in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of Section 1396a(n) is worthy of real deference. Appellees' arguments that Act §4714 is new law, despite Congress' unambiguous title for that section, cannot

override that deference, because those arguments incorrectly presume a clearly established meaning for Section 1396a(n)—something that simply did not exist before Act §4714 was adopted.

[8] We therefore honor Congress' "clarification" label and accept Act §4714's provisions as a statement of what Section 1396a(n) has meant all along. That moots all of appellees' constitutional objections to the new legislation, because those objections rest entirely on the assertedly retroactive, rather than declaratory, nature of Act §4714. But it is worth adding that we have, en route to our decision, carefully explored the litigants' arguments both as to the pre-Act version of Section 1396a(n) and as to the constitutional issues raised by appellees if Act §4714 were to be viewed as a retroactive change in, rather than a declaratory clarification of, the prior law—questions implicating the separation of powers, the Contract Clause and the Due Process Clause. And that exploration, which necessitated an effort on our part to parse the intricate and complex provisions of the pre-Act legislation, has only deepened our conviction that Congress' stated intention of clarifying that pre-existing law should be credited.

That leaves only one tag end for discussion, a statutory claim raised by the plaintiff Association in No. 96-55208 ("Beverly") that is unique to it as a provider of inpatient medical services to QMBs under Medicare Part A. Beverly argues in its supplemental brief that Medi-Cal's methodology for reimbursing hospitals for their Medicare expenses under Part A is not legal under either Beverly's or Secretary's interpretation of Act §4714(a)(2). Beverly urges this Court to affirm the district court's ruling below on that ground (under the familiar principle, as repeated in *Herrig v. FDIC*, 82 F.3d 282, 284 (9th Cir. 1996), that an appellate court may uphold a ruling on any basis that the record supports, even if it was not considered by the lower court).

But before an appellate court will consider such an issue, ordinarily the argument must have been raised sufficiently for

the trial court to rule on it (*A-1 Ambulance Serv. v. County of Monterey*, 90 F.3d 333, 338 (9th Cir. 1996), citing *In re E.R. Fegert Inc.*, 887 F.2d 955, 957 (9th Cir. 1989)). In this instance Beverly initially cited a single excerpt from the trial court record that it said had raised the statutory issue about Medi-Cal's Medicare Part A reimbursement policies. But post-argument its counsel has clarified its position as presenting a different assertion: that its current argument could not have been made below because it arose only as a result of standards set forth in the later-enacted Section 4714(a)(1), now codified as Section 1396a(n)(2).

[9] We need not resolve that newly-raised contention, nor does it call for a remand rather than a reversal. Any claim that California is violating the new federal statute—something that is necessarily not encompassed within the scope of the record as it was presented to the trial court and is thus not on review in the appeal before us—really represents the basis for a new lawsuit. Any such claim would call for the generation of a new record, against which a trial court could determine in the first instance whether there is anything to the contention that Act §4714's clarification of the prior law somehow renders the Medi-Cal reimbursement methodology for hospitals under Medicare Part A invalid. And in that respect the trial court would also have to determine whether despite the existence of the new enactment, Beverly's argument on that score is one that it could perhaps have raised the first time around, so that it might be held to have forfeited the argument by virtue of its not having done so in this original litigation.

Conclusion

For the reasons that we have stated here at some length, we conclude that Act §4714 is a clarification of the original intent of Congress when it passed Section 1396a(n). That being the case, the district courts' orders granting summary judgment in favor of each appellee are REVERSED. As a final point, we note that Director Belshe has not requested a remand in order

to seek to recoup any excessive payments made pursuant to the district court's orders. We indicate no view as to her right to obtain any such relief.

APPENDIX B — JUDGMENT OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION DATED JANUARY 4, 1996

HOOPER, LUNDY & BOOKMAN
LAWYERS
WATT PLAZA, SUITE 1600
1875 CENTURY PARK EAST
LOS ANGELES, CALIFORNIA 90067-2799
TELEPHONE (310) 551-8111

John R. Hellow, Bar No. 105814
Byron J. Gross, Bar No. 76626
Michele Melden, Bar No. 146951
Attorneys for Plaintiffs

JUDGMENT ON DECISION BY THE COURT

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA —
WESTERN DIVISION

CASE NO. 95-4053 JSL

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, *et al.*,

Plaintiffs,

v.

S. KIMBERLY BELSHÉ, as Director of the California Department of Health Services,

Defendant.

Appendix B

JUDGMENT

This action came for hearing before the Court on December 11, 1995 with Judge J. Spencer Letts presiding, and the issues having been duly heard and a decision having been duly rendered,

IT IS ORDERED AND ADJUDGED:

1. That summary judgment be granted in favor of plaintiffs on December 11, 1995.

IT IS FURTHER ORDERED THAT, commencing December 11, 1995:

1. Under 42 U.S.C. § 1396a(a)(10)(E)(i), the State of California is obliged to pay the full Medicare cost-sharing amounts on Medicare Part A inpatient hospital services provided to Qualified Medicare Beneficiaries (QMBs), as defined under federal law at 42 U.S.C. § 1396d(p)(1), as it did before May 1, 1994, and as provided in the State Plan amendment approved on June 24, 1994.

2. To the extent that Calif. Welf. & Inst. Code § 14109.5 and Calif. Code of Regs. § 51005(a)(2) can be read to allow the Department to deny cost-sharing for Medicare Part A inpatient hospital services provided to QMBs, they are invalid.

3. Defendant and her successors, officers, agents, servants and employees are permanently enjoined from implementing her policy of denying payment of Medicare cost-sharing amounts, as defined in federal law at 42 U.S.C. § 1396d(p)(3), for inpatient hospital services provided to QMBs.

Appendix B

4. The Order Granting Preliminary Injunction for Plaintiff HIA of California, Inc. (D/B/A Edgemont Hospital), dated October 10, 1995, is made permanent.

5. Defendant and her successors, officers, agents, servants and employees, commencing December 31, 1995, shall begin making full payment of Medicare cost-sharing amounts, as defined in federal law at 42 U.S.C. § 1396d(p)(3), for inpatient hospital services provided to QMBs, as it did before May 1, 1994, and as provided in the State plan amendment approved on June 24, 1994, for all claims not denied as of December 11, 1995.

6. Plaintiffs are the prevailing party; therefore, Defendant shall pay plaintiffs' costs and attorney's fees in this matter, the amount of which shall be provided in future orders.

Dated this 4th day of January, 1996, at Los Angeles, California.

Judge J. Spencer Letts
United States District Court

Presented by:
s/ Michele Melden
Michele Melden, Esq.
HOOPER, LUNDY & BOOKMAN, INC.
Attorneys for Plaintiff
Beverly Community Hospital Association

APPENDIX C — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION, GRANTING SUMMARY JUDGMENT, FILED DECEMBER 18, 1995

HOOPER, LUNDY & BOOKMAN
LAWYERS
WATT PLAZA, SUITE 1600
1875 CENTURY PARK EAST
LOS ANGELES, CALIFORNIA 90067-2799
TELEPHONE (310) 551-8111

John R. Hellow, Bar No. 105814
Byron J. Gross, Bar No. 76626
Michele Melden, Bar No. 146951

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA,
WESTERN DIVISION

CASE NO. 95-4053 JSL

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, *et. al.*,

Plaintiffs,

v.

S. KIMBERLY BELSHÉ, as Director of the California Department of Health Services

Defendant.

Appendix C

ORDER GRANTING SUMMARY JUDGMENT

Date: Dec. 11, 1995

Time: 3:00 p.m.

Room: Courtroom 4 (Judge Letts)

[stamp] THIS CONSTITUTES NOTICE OF ENTRY AS REQUIRED BY FRCP, RULE 77(d). [stamp]

Having carefully considered Plaintiffs' Motion for Summary Judgment, all Memoranda of Points and Authorities and Exhibits filed in support thereof, Defendant's Opposition, and Parties' arguments on December 11, 1995, THE COURT ORDERED that Summary Judgment be granted in favor of Plaintiffs on December 11, 1995.

IT IS FURTHER ORDERED THAT, commencing December 11, 1995:

1. Under 42 U.S.C. § 1396a(a) (10) (E) (i), the State of California is obliged to pay the full Medicare cost-sharing amounts on Medicare Part A inpatient hospital services provided to Qualified Medicare Beneficiaries (QMBs), as defined under federal law at 42 U.S.C. § 1396d(p)(1), as it did before May 1, 1994, and as provided in the State Plan amendment approved on June 24, 1994.

2. To the extent that Calif. Welf. & Inst. Code § 14109.5 and Calif. Code of Regs. § 51005(a) (2) can be read to allow the Department to deny cost-sharing for Medicare Part A inpatient hospital services provided to QMBs, they are invalid.

3. Defendant and her successors, officers, agents, servants and employees are permanently enjoined from implementing her policy of denying payment of Medicare cost-sharing amounts, as defined in federal law at 42 U.S.C. § 1396d(p) (3), for inpatient hospital services provided to QMBs.

4. The Order Granting Preliminary Injunction for Plaintiff HIA of California, Inc. (D/B/A Edgemont Hospital), dated October 10, 1995, is made permanent.

5. Defendant and her successors, officers, agents, servants and employees, commencing December 31, 1995, shall begin making full payment of Medicare cost-sharing amounts, as defined in federal law at 42 U.S.C. § 1396d(p) (3), for inpatient hospital services provided to QMBs, as it did before May 1, 1994, and as provided in the State Plan amendment approved on June 24, 1994, for all claims not denied as of December 11, 1995.

6. Plaintiffs are the prevailing party; therefore, Defendant shall pay plaintiffs' costs and attorney's fees in this matter, the amount of which shall be provided in future orders.

Dated: December 18, 1995

s/ J. Spencer Letts
Judge J. Spencer Letts
United States District Court

Presented by:

John R. Hellow, Esq.
COOPER, LUNDY & BOOKMAN, INC.
Attorneys for Plaintiff
Beverly Community Hospital Association

APPENDIX D — ORDER OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT FILED MARCH 3, 1998

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

NO. 96-55208

D.C. NO. CV-95-4053 JSL

BEVERLY COMMUNITY HOSPITAL ASS'N

Plaintiff-Appellee,

v.

S. KIMBERLY BELSHE, Director of the California Dep't of Human Services,

Defendant-Appellant.

Nos. 96-56249
96-56485
96-56648
97-55022

D.C. Nos. CV-96-2322-JSL
CV-96-3033-JSL

Appendix D

CALIFORNIA AMBULANCE ASS'N,
CALIFORNIA MEDICAL ASS'N, *et al.*

Plaintiffs-Appellees,

v.

S. KIMBERLY BELSHE, Director of the California Department of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services

Defendants-Appellants.

Nos. 96-56699
96-56745
96-55713
97-55220

D.C. Nos. CV-96-5564-JSL

RICHARD GILMORE, *et al.*,

Plaintiffs-Appellees,

v.

S. KIMBERLY BELSHE, Director of the California Dep't of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services

Defendants-Appellants.

Appendix D

ORDER

Before: REINHARDT and TASHIMA, Circuit Judges, and SHADUR, District Judge.**

The panel has voted to deny the petitions for rehearing and to reject the suggestions for rehearing en banc. The full court has been advised of the suggestion for rehearing en banc, and no judge of the court has requested a vote on the suggestions for rehearing en banc. Fed. R. App. P. 35(b)

The petitions for rehearing are denied and the suggestions for rehearing en banc are rejected.

** The Honorable Milton I. Shadur, Senior United States District Judge for the Northern District of Illinois, sitting by designation.

APPENDIX E — STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

42 U.S.C. § 1369(a)(10)(E)(i)

§ 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must —

* * *

(10) provide —

* * *

(E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;

* * *

42 U.S.C. § 1369a(n)

(n) Payment amounts

(1) In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under subchapter XVIII of this chapter for the service would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2) —

> (A) for purposes of applying any limitation under subchapter XVIII of this chapter on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under subchapter XVIII of this chapter plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;
>
> (B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1396b(m)(1)(A) of this title for the service; and
>
> (C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this subchapter or subchapter XVIII of this chapter shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

Appendix E

* * *

42 U.S.C. § 1396(d)(p)(3)

* * *

(3) The term "medicare cost-sharing means (subject to section 1396a(n)(2) of this title) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1359i-2 or 1395i-2a of this title, and

(ii) premiums under section 1395r of this title.

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e and section 1395(b) of this title).

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

* * *

Appendix E

BALANCED BUDGET ACT OF 1997, PUB. L. 105-33 § 4714, 111 STAT. 251, 509-10

SEC. 4714. MEDICAID PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING.

(a) CLARIFICATION REGARDING STATE LIABILITY FOR MEDICARE COST-SHARING. —

(1) IN GENERAL. — Section 1902(n) (42 U.S.C. 1396a(n)) is amended —

(A) by inserting "(1)" after "(n)", and

(B) by adding at the end the following:

"(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

"(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2) —

"(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service the amount of payment made under

title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

"(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and

"(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.".

(2) CONFORMING CLARIFICATION. — Section 1905(p)(3) (42 U.S.C. 1396(p)(3)) is amended by inserting "(subject to section 1902(n)(2))" after "means".

(b) LIMITATION ON MEDICARE PROVIDERS. —

(1) PROVIDER AGREEMENTS. — Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended —

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the comma at the end the following: ", and (ii) not to impose any charge that is prohibited under section 1902(n)(3)".

Appendix E

(2) NONPARTICIPATING PROVIDERS. — Section 1848(g)(3)(A) (42 U.S.C. 1395w-4(g)(3)(A)) is amended by inserting before the period at the end the following: "and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section".

(c) EFFECTIVE DATE. — The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of section 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act.

Appendix E

UNITED STATES CONSTITUTION, AMENDMENT V

* * * nor shall private property be taken for public use, without just compensation.

UNITED STATES CONSTITUTION, ARTICLE III

SECTION 1. The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office.

SECTION 2. The judicial Power shall extend to all Cases, in Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made, or which shall be made, under their Authority; — to all Cases affecting Ambassadors, other public Ministers and Consuls; — to all Cases of admiralty and maritime Jurisdiction; — to Controversies to which the United States shall be a Party; — to Controversies between two or more States; — between a State and Citizens of another State; — between Citizens of different States; — between Citizens of the same State claiming Lands under Grants of different States, and between a State, or the Citizens thereof, and foreign States, Citizens or Subjects.

In all Cases affecting Ambassadors, other public Ministers and Consuls, and those in which a State shall be Party, the Supreme Court shall have original Jurisdiction. In all the other

Appendix E

Cases before mentioned, the supreme Court shall have appellate Jurisdiction, both as to Law and Fact, with such Exceptions, and under such Regulations as the Congress shall make.

The Trial of all Crimes, except in Cases of Impeachment, shall be by Jury; and such Trial shall be held in the State where the said Crimes shall have been committed; but when not committed within any State, the Trial shall be at such Place or Places as the Congress may by Law have directed.

SECTION 3. Treason against the United States, shall consist only in levying War against them, or in adhering to their Enemies, giving them Aid and Comfort. No Person shall be convicted of Treason unless on the Testimony of two Witnesses to the same overt Act, or on Confession in open Court.

The Congress shall have Power to declare the Punishment of Treason, but no Attainder of Treason shall work Corruption of Blood, or Forfeiture except during the Life of the Person attainted.

APPENDIX F — EXHIBIT TO SUPPLEMENTAL BRIEF TO UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT BY APPELLEES CALIFORNIA AMBULANCE ASS'N AND CALIFORNIA MEDICAL ASS'N ET AL.

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

August 12, 1997

Honorable Franklin D. Raines
Director
Office of Management and Budget
Washington, D.C. 20503

Dear Mr. Raines:

The Congressional Budget Office, after consulting with the Committees on the Budget of the House of Representatives and the Senate, provides the enclosed estimates of the effects of H.R. 2014 (Public Law 105-34), the Taxpayer Relief Act of 1997, and H.R. 2015 (Public Law 105-33), the Balanced Budget Act of 1997, on direct spending and receipts. These estimates are required by section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. H.R. 2014 and H.R. 2015 were cleared by the Congress on July 31 and signed by the President on August 5. Section 10213 of H.R. 2015 provides that these two laws are not counted for pay-as-you-go purposes.

On August 11 the President identified on provision of Public Law 105-33 and two provisions of Public Law 105-34 for cancellation under the terms of the Line Item Veto Act. CBO's estimates do not reflect the effects of the proposed cancellations.

Appendix F

Sincerely,

s/ June E. O'Neill
June E. O'Neill

Enclosures

Appendix F

BUDGETARY IMPLICATIONS OF THE BALANCED BUDGET ACT OF 1997

SUMMARY AND INTRODUCTION

As part of a plan to balance the federal budged by 2002, the 105th Congress enacted and President Clinton signed two major pieces of legislation: The Taxpayer Relief Act of 1997 (H.R. 2014/ Public Law 105-34) and the Balanced Budget Act of 1997 (H.R. 2015/Public Law 105-33). The Balanced Budget Act achieves $127 billion in net deficit reduction over the 1998-2002 period. Gross savings of $160 billion comprise:

- $112 billion from slowing the growth of the Medicare program;
- $21 billion from auctioning licenses to use portions of the electromagnetic spectrum;
- $7 billion from changes to Medicaid;
- $15 billion from other spending reductions and tax increases.

These savings are partly offset by additional spending of $33 billion:

- $20 billion for children's health insurance initiatives and
- $13 billion to mitigate the effects of last year's welfare reform law.

The act also extends the limits on discretionary spending and the pay-as-you-go procedures for direct spending and receipts, but these provisions do not directly alter federal outlays or revenues. The summary table provides estimates of the act's budgetary effects by title. The following pages give details by program and provisions.

* * *

percent of costs in 2002, and 70 percent of costs in 2003. By 2003, CBO estimates that states will maintain reimbursement rates to FQHCs and rural health centers at a level consistent with overall Medicaid payment rates. This provision will reduce Medicaid costs by $0.3 billion over the next five years, compared with prior law.

Medicaid Rates as Payment in Full. In recent years, many states have been required by court decisions to pay full Medicare rates for cost sharing for QMBs and people dually eligible for Medicare and Medicaid. This provision overturns these decisions and gives states the option not to pay providers Medicare cost sharing amounts in excess of Medicaid rates. According to the Physician Payment Review Commission, Medicaid payments rates are on average about 73 percent of Medicare payment rates. Limiting payment rates to providers for QMBs and dual eligibles to the lower payment rates will generate about $5 billion in federal Medicaid savings. However, CBO assumes that about one-third of the combined federal and state savings will be offset by behavioral responses by providers in the Medicare program, increasing Medicare costs by about $2.9 billion. The net federal savings in the two programs will be about $2.1 billion.

* * *

Appendix F

Treatment of Veterans' Pensions Under Medicaid. Under prior law, payments by the Department of Veterans Affairs for aid and attendance were not counted toward income for veterans in state veterans homes. This provision will count these payments as income, thus reducing Medicaid's contribution to the cost of veterans' institutional care. CBO estimates that this provision will reduce Medicaid outlays by $0.1 billion over five years.

Federal Payments to States. This provision specifies allotments that will limit the amount of federal reimbursement available for state disproportionate share hospital (DSH) programs, waives certain provider tax provisions for New York, provides funding for health services furnished to undocumented aliens, provides new tools to combat fraud and abuse, increases the federal medical assistance percentage (FMAP) for Alaska and the District of Columbia, and increases payment limits for the territories.

Limits on Disproportionate Share Hospital (DSH) Payments. The provision establishes specific state allotments for DSH payments for each year in the 1998-2002 period. For 2003 and later years, allotments will equal the lower of the previous year's allotment increased by the Consumer Price Index for medical services for the previous fiscal year or 12 percent of a state's medical assistance expenditures. The provision also limits state DSH expenditures for institutions for mental diseases (IMDs) in 1998 through 2000 to the lesser of the amount spent on those institutions in 1995 or the percent of DSH spending on those institutions in 1995 applied to the 1998-2000 allotments. The amount of DSH spending for mental health will be held to 50 percent of DSH spending in 2001, 40 percent of DSH spending in 2002, and 33 percent of DSH spending in succeeding fiscal years. CBO estimates that these limitations will prevent some states from spending up their allotments. On

* * *

Table 4D.--Estimated Budgetary Impact of Subtitle H, Medicaid

(By fiscal year, in billions of dollars)	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2002 Total	1998-2007 Total
Chapter 1 - Managed Care												
Application of standards for emergency conditions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
Chapter 2 - Flexibility in Payment of Providers												
Repeal of Boren requirements	0.0	-0.1	-0.2	-0.4	-0.5	-0.7	-0.9	-1.1	-1.4	-1.8	-1.2	-8.9
FQHC payment reform	-0.0	-0.0	-0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-1.3
Medicaid rates for Medicare cost sharing for QMB and dually eligible beneficiaries												
Medicaid	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-1.7	-1.8	-5.0	-12.~
Medicare Benefits	0.5	0.5	0.6	0.6	0.7	0.7	0.8	0.9	1.0	1.0	2.9	7.3
Treatment of Veteran's Pensions	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.2
Chapter 3 - Federal Payments to States												
Reforming DSH payments /a	-0.1	-1.0	-2.1	-3.2	-4.1	-4.8	-5.2	-5.9	-6.7	-7.8	-10.4	-40.4
Treatment of state taxes	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
Additional funding of emergency health services for illegal aliens	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Elimination of waste fraud and abuse /b	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0
Increased FMAPs for Alaska and DC	0.2	0.2	0.3	0.2	0.2	0.2	0.2	0.3	0.3	0.3	1.1	2.5
Increase payment limits for the territories	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.4
Chapter 4 - Eligibility												
Option for 12 month continuous eligibility	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.7	1.8
Payment of Medicare Part B premium assistance - Medicare Spending	0.2	0.3	0.3	0.4	0.4	0.0	0.0	0.0	0.0	0.0	1.5	1.5
State option to buy in disabled workers /b	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Chapter 6 - Administration and Miscellaneous												
Extension of moratorium for certain IMDs /b	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Subtitle H, Total Change in Medicaid	-0.4	-1.8	-2.9	-4.3	-5.5	-6.3	-7.2	-8.3	-9.4	-10.7	-14.8	-58.4
Subtitle H, Total Change in Medicare	0.7	0.8	0.9	1.0	1.1	0.7	0.8	0.9	1.0	1.0	4.4	8.8

SOURCE: Congressional Budget Office

NOTE: Components may not sum to totals because of rounding.

a. Estimate includes interaction with Children's Health Insurance Programs and other welfare programs.
b. Less than $50 million over the 1998-2002 period.

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SUPREME COURT, U.S.

No. 97-1947, No. 97-1949, No. 97-2079

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1997

BEVERLY COMMUNITY HOSPITAL ASS'N, *Petitioner*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, *Respondent*.

CALIFORNIA AMBULANCE ASS'N and CALIFORNIA MEDICAL ASS'N, et al., *Petitioners*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, and DONNA E. SHALALA, Secretary, United States Dept. of Health and Human Services, *Respondents*.

RICHARD GILMORE, et al., *Petitioner*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, and DONNA E. SHALALA, Secretary, United States Dept. of Health and Human Services, *Respondents*.

On Petition for Writ Of Certiorari To The United States Court of Appeals for the Ninth Circuit

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BRIEF IN OPPOSITION TO PETITIONS FOR WRITS OF CERTIORARI

DANIEL E. LUNGREN
Attorney General
CHARLTON G. HOLLAND, III
Senior Assistant Attorney General
Counsel of Record
50 Fremont St., Room 300
San Francisco, CA 94105
Telephone: (415) 356-6309
Fax: (415) 356-6301
Counsel for State Respondent

42 pp

QUESTION PRESENTED

Is California's interpretation of 42 U.S.C. section 1396a(n) correct in light of the fact the Secretary of the Department of Health and Human Services shared that interpretation, that Congress ratified that interpretation by clarifying legislation and that the interpretation is consistent with the statutory scheme regarding qualified medicare beneficiaries?

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PREFACE

S. Kimberly Belshé, Director ("California") of the Department of Health Services of the State of California hereby files this Brief in Opposition to the petitions for writs of certiorari filed by the Petitioners in California Ambulance Ass'n and California Medical Ass'n v. S. Kimberly Belshé et al., No. 97-2079 (herein "Associations"), Richard Gilmore, M.D., et al. v. Donna E. Shalala, et al., No. 97-1949 (herein "Gilmore", and Beverly Community Hospital Ass'n, et al. v. S. Kimberly Belshé. No. 97-1947 (herein "Beverly"). The Secretary of the United States Department of Health And Human Services will be refereed to as the "Secretary."

INTRODUCTION

The brief in opposition filed by California to the petitions for writ of certiorari filed by the three Petitioners is combined because the statutes, cases and issues in question in these petitions are essentially identical. Therefore, no purpose would be served by filing separate, identical briefs in opposition to each petition.

California does not dispute the jurisdictional statements (California Ambulance Ass'n, p. 1, Gilmore, p. 1, Beverly, p. 1), the constitutional provisions and statutes involved, (California Ambulance Ass'n, p. 1, Gilmore, p. 1, Beverly, p. 1), set forth in each petition. California does not dispute the description by each petitioner of the sequence of events in the trial court and the Ninth Circuit. (Gilmore, p. 8-10, California Ambulance Ass'n, p. 8-10, Beverly, p. 2-5,) California does not agree with the questions presented by the Petitioners.

SUMMARY OF ARGUMENT

The petitions do not state any compelling reason under Rule 10 for this Court to grant certiorari. There is no conflict among the circuits because the two circuit decisions after the enactment of section 4714 reached the same result. California and the Secretary are correct in their interpretation of the role section 1396a(n) plays in the payment permitted the states to providers' regarding crossover claims. It is not convincing to argue that Congress did not really "clarify" prior legislation because Congress did not narrowly make the clarification but did its best to put the issue at rest. This Court has a reasonable and venerable rule regarding the weight it gives to Congress's clarification of statutory policy, which was applied properly by both circuits and which does not need further elaboration, and which is not in conflict with any other maxim of statutory interpretation. Whatever life the Klein decision might have, this action is not the place to explore its vitality because Congress did not create a rule of decision that would bind the judiciary. Finally, in California no provider under Medicaid had a reasonable expectation that it would receive 100% of the amount it charged for the services it rendered to the beneficiaries of the Medicaid Program who are the subject of this action.

STATEMENT OF THE CASE

STATUTORY AND REGULATORY BACKGROUND

1. Medicaid/Medi-Cal.

The Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., was enacted by Congress in 1965. Medicaid is a need-based cooperative federal and

state cost sharing venture that enables each state "as far as practicable under the conditions in such State," to provide necessary medical assistance to families and individuals with insufficient income and resources. See, Pub. L. No. 89-97, 79 Stat. 286 (1965), as amended, 42 U.S.C. 1396 et seq. A state is not required to participate in the Medicaid program, but if it chooses to participate it must comply with the Medicaid Act and its implementing regulations. 42 U.S.C. 1396c.

Under Medicaid, each state has a fee schedule or methodology that establishes a rate for every item or service covered under the state's Medicaid plan. California's Medicaid rates are almost always less than the allowable charge for services under Medicare. Participating providers must accept the Medicaid payment, together with any nominal co-payment obligations, as payment in full for services and amounts covered under the state plan.

The methods, procedures and payment levels for Medicaid services must be under 42 U.S.C. § 1396a(30)(A):

> "as necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Therefore, during the period covered by this litigation, the states were obligated to maintain Medicaid rates at a level sufficient to attract sufficient providers to

provide items and service to the relevant patient (including the QMB) population. The Petitioners (and Amicus) do not contend that the level of the Medicaid rates is inconsistent with section 1396a(30)(A).

Medicaid is the payer of last resort, which is to say that "other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 146, 99th Cong., 2d Sess. 1, 312 (1986), reprinted in 1986 USCCAN 42, 279. See, 42 U.S.C. 1396a(a)(25). The Secretary's regulations require the states to reimburse a provider only to the extent that the state's Medicaid rate exceeds the third-party payment. 42 C.F.R. 433.139(b)(1). The Secretary views Medicare as a third party insurer under these regulations.

2. Medicare.

Enacted in 1965, Title XVIII of the Social Security Act is commonly known as the Medicare Act. See, Pub. L. No. 89-97, 79 Stat. 291 (1965), as amended, 42 U.S.C. 1395 et seq. Individuals who are at least 65 years of age or disabled (and meet certain other eligibility requirements) are automatically covered in Part A of the Medicare program, which provides reimbursement for inpatient hospital care and related post-hospital, home health and hospice care for aged and disabled beneficiaries. 42 U.S.C. 1395c-1395i-4 (1995). Under Part A, the federal government pays a health care provider's reasonable cost for covered services, less deductibles and coinsurance. Medicare beneficiaries who receive Part A services are responsible for paying "deductibles" (a fixed and limited amount of money toward the charge of hospital care) and "coinsurance" (a percentage of reasonable cost for each day of care after the first sixty

days). Some individuals also pay a premium. 42 U.S.C. § 1395e; 42 C.F.R. § 409.80. These are referred to herein as "Medicare cost-sharing amounts."

Part B is a voluntary insurance program pursuant to which eligible individuals may purchase supplementary insurance for hospital out-patient services, physician services, and other medical services not covered under Part A. 42 U.S.C. 1395j; 42 U.S.C. 1395l(a)(1); 42 U.S.C. 1395l(b).

Generally the federal government pays 80% of the allowable charges for Medicare beneficiaries who receive Part B services. The beneficiaries are responsible for paying deductibles (a fixed and limited amount), and coinsurance or copayments (a percentage of the reasonable value of the service). 42 U.S.C. § 1395e; 42 U.S.C. § 1396d(p)(3). The amounts beneficiaries are responsible for are referred to above and throughout - as with Part A - as "Medicare cost-sharing amounts."

3. The QMB Provisions.

A. The QMB Program.

Between 1967 and 1986, states were required to pay cost-sharing only on behalf of persons eligible for both programs. In 1986, Congress broadened the class of persons eligible for such coverage beyond these dual eligible. Pub.L. No. 99-509, §9403, 100 Stat. 2053-2056. The 1986 amendments provided that "at the option of a State" the State Plan could "provide for making medical assistance available for medicare cost-sharing" for "qualified medicare beneficiaries." *id.* §9403(a)(3), 100 Stat. 2053.[1] (42 U.S.C. § 1396(a)(10)(E)(i).)

---

1. At the time, QMB's were defined as persons (1) who were eligible for Medicare Part A but not otherwise eligible for Medicaid,

The states' obligations with regard to this new category of individuals were addressed in two subsections of section 9403. Section 9403(c)(2) provided that "the medical assistance made available to a qualified medicare beneficiary * * * shall be limited to medical assistance for medicare cost-sharing * * * subject to the provisions of subsection (n) [of this section]." Pub. L. No. 99-509, § 9403(c), 100 Stat. 2054 (codified in clause (VIII) in the matter following 42 U.S.C. § 1396a(a)(10)(F)) (emphasis supplied). The new Section "n," -- Section 9403(e) of the Public Law, (codified at 42 U.S.C. 1396a(n)) -- was entitled "Payment Amounts." It specified that states "may" provide for payment of Medicare cost-sharing in an amount "that results in the sum of such payment amount and any amount of payment made under [Medicare] * * * exceeding the amount that is otherwise payable under the State [i.e. Medicaid] plan * * *." Id. § 9403(e), 100 Stat. 2055. Thus, Congress expressed its intention that states not be required, although they might choose, to pay coinsurance on behalf of QMBs in amounts that exceeded the charges "otherwise payable" under the state's approved Medicaid plan.

B. 1998: Expansion of the QMB Program

The 1986 amendments, allowing states to pay cost-sharing for pure QMBs, had a limited practical effect: By 1988, only one state had chosen to purchase Part B Medicare for pure QMBs. H.R. Rep. No. 100-105(II), 100th Cong., 2d Sess. 59 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 882. It was in 1988 that Congress for

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(2) whose income did not exceed an amount set by the state but not more than 100% of the poverty line, and (3) whose resources did not exceed the Supplemental Security Income (SSI) program's maximum. *id.* §9403(b) (42 U.S.C. § 1396d(p)(1).)

the first time mandated that states make medicare cost-sharing available to persons not otherwise eligible for Medicaid assistance, *i.e.*, to pure QMBs. Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748 (deleting "at the option of the State" from 42 U.S.C. § 1396a(a)(10)(E)(i)). In the same bill that Congress thus first mandated coverage of pure QMBs, it also expanded the pool of those eligible to be QMBs by doubling the amount of resources an individual could own without losing QMB status. *Id.* § 301(c)(2) (codified at 42 U.S.C. §1396d(p)(1)(C)).

When it imposed these new obligations on the states, Congress was aware of the prior, practical construction of the law that states had discretion whether to make cost sharing payments over the Medicaid fee amount:

> It is the understanding of the Committee that, with respect to dual Medicaid-Medicare eligible, some States pay the coinsurance even if the amount Medicare pays for the service is higher than the State Medicaid payment rate, while others do not. Under the Committee bill, States would not be required to pay the Medicare coinsurance in the case of a bill where the amount reimbursed by Medicare -- i.e., 80 percent of the reasonable charge -- exceeds the amount Medicaid would pay for the same item or service. However, if a State chooses to pay some or all of the co-insurance in this circumstance, Federal matching funds would, as under current law, be available for this cost.

H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 884.

Later in 1988, Congress changed the statutory definition of QMB to its current form, so that now it

includes both pure QMBs and dual eligible. Pub. L. No. 100-647, § 8434(a), 102 Stat. 3342, 3805. The accompanying House Conference Report explained that all Medicare-eligible persons with income and resources under the limits set by 42 U.S.C. 1396d(p)(1), are to be considered QMBs, "whether or not they are otherwise eligible for Medicaid." H.R. Conf. Rep. No. 1104, 100th Cong. 2d Sess. (1988), *reprinted in* 1988 U.S.C.C.A.N. 5048, 5344.

Finally, in 1989, Congress amended the Medicare Act to require that physicians treating QMBs accept assignment from Medicare, thereby precluding the billing of QMBs in excess of the fee schedule amount set by Medicaid. Pub. L. No. 101-239, § 6102, 103 Stat. 2106 (1989) (codified at 42 U.S.C. § 1395w-4(g)(3)(A)). In so doing, the House Report considered the current practices of the States, as approved by the Secretary, regarding Medicaid payment of coinsurance for QMBs and ratified this practice: "The Medicaid programs typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service in question * * *. The Committee bill * * * does not change the current policy regarding the amount which a Medicaid program must reimburse on such claims. H.R. Rep. No. 247, 101st Cong., 1st Sess. 364 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2090 (emphasis added).

C. California's Implementation - Part A.

California's policy regarding reimbursement for providers of inpatient hospital services has been consistent since the enactment of California Welfare & Institutions Code § 14109.5 (effective January 1, 1982). However,

California's ability to effectuate the policy has been dependent on its Medicaid agency's, the Department of Health Services, ability to identify comparable services, which initially was not possible with hospital inpatient services. In 1992, section 14109.5 was amended to direct the Department to look toward Medicare itself for establishing rates for comparable hospital inpatient services, which the Department did pursuant to 42 U.S.C. § 1396a(a)(13)(A) ("the Boren Amendment") (now repealed, P.L. 105-33, 111 Stat. 251, sec. 4711 (1997)). When the Department had completed its required Boren Amendment analysis, it concluded that the amounts paid - as contrasted with the rates charged by the providers - by Medicare were reasonable and adequate reimbursement for the providers of inpatient hospital services to beneficiaries eligible for both Medicare and Medi-Cal. Accordingly, in 1994 the Department adopted the Medicare level of payment as its standard for reimbursement for services rendered to beneficiaries who are eligible for both Medicare and Medi-Cal.

D. California's Implementation - Part B.

Prior to January 1, 1982 California paid all deductibles and coinsurance costs on behalf of all enrollees under the Part B buy -in agreement. California's buy-in agreement was amended and approved by the Secretary, effective January 1, 1982, capping payment under the buy-in agreement to the maximum Medi-Cal (Medicaid) payment for the same service. (Samuel v. California Department of Health Services (N.D. Cal. 1983) 570 F.Supp. 566, as modified, 572 F.Supp. 273.)

Samuel held that under a buy-in agreement when California pays the Part B premiums the Medicare Part B coverage thereby becomes part of the Medi-Cal program's

scope of benefits. By holding that a health care provider that accepts a crossover beneficiary therefore must accept the patient as a Medi-Cal patient and by prohibiting providers from seeking further reimbursement from beneficiaries, the Court approved California's rate limitation for Part B services. (Samuel at p. 573.)

Hence, notwithstanding the expansion in the class of beneficiaries a state may include in its Medicaid state plan and buy-in agreement, Samuel holds that the program remains a Medicaid program pursuant to which a state may purchase some or all of the benefits provided through Medicare Part B (and by extension Part A) and is not required to reimburse providers at higher than the Medicaid rate.

E. The Litigation.

Once Congress passed the 1988 legislation, providers saw an opportunity to close the gap between what had always been a difference in payment and which had been approved in California under Samuel. Four Circuit Courts held, with dissents and with different views on the meaning of 1396a(n) and the policy motivating Congress in 1986 and 1988, that the providers were entitled to the higher Medicare rate. Rehabilitation Ass'n of Virginia v. Kozlowski, 42 F.3d 1444 (4th Cir.), (Niemeyer, J. dissenting), cert. denied, 116 S. Ct. 60 (1995) ("Kozlowski"); Haynes Ambulance Service v. Alabama, 36 F.3d 1074 (11th Cir. 1994) ("Haynes"); Pennsylvania Medical Soc'y v. Snider, 29 F.3d 886 (3d Cir. 1994) ("Snider"); New York City Health & Hosp. Corp. v. Perales, 954 F.2d 854 (2d Cir.), (Cardamone, J., dissenting) (cert. denied, 113 S. Ct. 461 (1992) ("Perales").

Later, in California, Judge Letts of the Central District agreed with the result of these decisions and entered judgment for the providers in the three cases in this action. In the Northern District, Judge Legge in Dameron Physicians Medical Group, Inc. v. Shalala, et al., 961 F.Supp. 1326 (N.D.Cal. 1997) reached the opposite conclusion:

> "In the absence of a clear answer in the statutory language, and in light of the United States Supreme Court's decision in Chevron and the Ninth Circuit's decision in Stephenson, this court must accept the defendants' interpretation of the statutes at issue. California may cap its payments at the Medi-Cal maximum levels." (Id. at 1333.)

The district courts in Snider, Haynes, and Perales had agreed also with the position taken by California and the Secretary.

Aside from the conflicting district court decisions, the various positions taken in the opinions justify the rule that deference should be given to the Secretary when the statutory scheme is unclear. In Snider, the court concluded that Congress' policy to make the crossover program mandatory was to force the states to expend a projected windfall on the elderly poor. (Id. at 902) Whether that intent was true, there was no legislative history Congress wanted the money to go to providers. In Perales, the court concluded Congress' policy was to prevent a two tiered reimbursement system for crossover beneficiaries. (Id. at 858-859.) However, the Perales court could only justify Congress' policy based upon tenuous inferences drawn from Congress' 1965 policy relating to the difference between private pay and

Medicare patients. (Ibid.) Haynes adopted Snider in its analysis. In Kozlowski, the court held, with Justice Niemeyer offering a different analysis, that the permissive language in section 1396a(n) is limited to the option the states possessed prior to 1988 to pay a higher Medicare benefits to "pure" QMBs than to dual eligible. The irony, in light of the Petitioners' argument that any attempt at clarification of policy by Congress should be ignored by the judiciary or given little weight, is that the circuits justified their interpretation of QMB reimbursement scheme based upon a search for the policy of Congress.

F. The Balanced Budget Act of 1997.

Given the litigation that developed regarding Congress's intention in the 1988 legislation, the welter of conflicting district and court of appeals decisions, and the conflict between the providers, on the one hand, and the states and Secretary on the other, Congress enacted section 4714 of the Balanced Budget Act of 1997 ("BBA") (P.L. 105-33, 111 Stat. 251, eff. August 5, 1997) entitled a "clarification regarding state liability for medicare cost-sharing." Congress amended section 42 U.S.C. section 1396a(n) to read as follows:

> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred related to payment for deductible, coinsurance, or copayments for medicare cost sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

Congress also provided that its clarification applied to existing litigation:

> (c) EFFECTIVE DATE.--The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is subject of a law suit that is based on the provisions of section 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act."

The Committee of Conference statement describes Congress understanding of pre-BBA law:

> "State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare, (dual eligible) and for qualified Medicare beneficiaries (QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards.) The amount of the required payment has been the subject of some controversy.State Medicaid Programs frequently have lower payment rates for services than the rates that would be paid under Medicare. Program guidelines permit states to pay either (1) the full Medicare deductible and coinsurance amounts or (2) cost-sharing charged only to the extent that the Medicare provider has not

received the full Medicaid rate for an item or service. Some courts have forced state medicare programs to reimburse Medicare provider to the full Medicare allowable rates for services provided to QMBs and dually eligible individuals." (See H. Conf. Rep. No 105-217, 105th Cong. 1st Sess. 870-870 reprinted in 1997 U.S.C.C.A.N 176, 491-492)

The report then concluded that the amendment:

"Clarifies that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state' Medicaid program would have paid for such service to a recipient who is not a QMB. Specifies that the Medicare payment plus the state' Medicaid payment will be considered payment in full and the QMB will not be liable for payment to a provider or managed care entity. Additionally provides that any sanction for excess charges that may be imposed on a provider or managed care entity under Medicare may be imposed for making excess charged under Medicaid. Applies to items and services furnished on or after the date of enactment. In the case of payment that is subject to a law suit that is pending as of the date of enactment, or initiated after the date of enactment, applies to items and services furnished before the date of enactment." (Ibid.)

G. Wisdom comes eventually - Beverly and Paramount decisions in favor of the Secretary and California.

The Ninth Circuit decided the case that is the subject of these petitions, Beverly Community Hospital Ass'n v. Belshe, 132 F.3d 1259 (9th Cir. 1997) and the Seventh Circuit decided Paramount Health Systems, Inc. v. Wright, 138 F.3d 706 (7th Cir. 1998). Both of these courts recognized that Congress' intent pre-BBA was unclear in relation to QMBs and that, giving deference to Congress' expression of clarification in section 4714, weighed the balance in favor of the interpretation taken by California and the Secretary.

In Beverly the court pointed out that "Section 1396a(n) is a superb example of the baffling nature of [the Medicaid and Medicare acts]." (Id. at 1266.) "It has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification." (Ibid.) In Paramount, although the court mused whether section 4714 really was a proper clarification, eventually it concluded the place of section 1396a(n) in Congress' scheme of reimbursement was sufficiently ambiguous to accept the interpretation of California and the Secretary, to wit:

> The Act is a hopeless muddle so far as [QMB] reimbursement is concerned, and while it seems to us that [the health providers have] the better interpretation, there is sufficient ambiguity to require us to defer to the government." (Id. at 711.)

Beverly and Paramount have been followed in McCreary, M.D. et al. v. Offner, et al., 1 F.Supp. 2d 32 (D.D.C. 1998) in which Judge Friedman of the District of Columbia District Court held:

> Whether one scrutinizes the clarifying claims of Section 4714 with a harsher gaze or not, one thing is clear: the law regarding state liability to pay for the health services provided to QMBs has never been crystal clear. Section 4714 has certainly provided clarification where it was needed. For this reason, the Court concludes that applying Section 4714 retroactively, as Congress directed, is not impermissible under the Constitution." (Emphasis supplied.) (Id at 49.)

The question now is whether this Court should accept the Petitioners' invitation to enter this "muddle" and resolve the issue.

REASONS FOR THIS COURT NOT TO GRANT THE PETITIONS FOR CERTIORARI

1. Although California and the Secretary are correct in their interpretation of section 1396n(a) in the context of QMBs and the evolution of their eligibility for Medicaid, arguably the provisons are ambiguous so the Secretary's interpretation should have been given Chevron deference.

In essence, the Petitioners are petitioning this court on their interpretation of section 1396a(n) as it existed pre-BBA. Whatever section 4714 did, it affirmed Congress' policy that states do not have to pay providers of Part A and B services to QMBs at the

Medicare rate. Accordingly, the Petitioners are contending for an interpretation of section 1396a(n) and a basic policy position about reimbursement that Congress is unwilling to support.

California is correct regarding its interpretation of its reimbursement duty under Medicaid. Medicaid is the payor of last resort. The statutory scheme is that all other sources of payment must be exhausted before the Medicaid program is available for payment. California has been consistent in this scheme. Until Judge Letts issued his order in 1996, California's Medicaid program did not reimburse providers more than the Medicaid rate for QMBs.

Part A was different but only because a difficulty existed in determining for hospital services what was the Medicaid rate in relation to the Medicare rate. Once that Medicaid rate was established in 1994 by California's Medicaid agency, Part A was applied consistently with reimbursement under Part B.

It is clear that Congress intended in 1988 to mandate the states to include QMBs as part of the Medicaid program. Few states had voluntarily joined - unquestionably owing to the financial burden that joinder would impose. In that light, without a clear expression of intent, it does not make sense for Congress to both mandate QMBs into the Medicaid program and to burden the states with additional financial costs - which they had been unwilling to assume - without a clear expression that the providers would benefit from this change in the law.

To the contrary, Congress left section 1396a(n) untouched in 1988 in order to preserve the states

flexibility in responding to this mandatory addition to the Medicaid program. As we pointed out above, Medicaid is a jointly funded federal-state program. As a joint spending program, "if Congress intends to impose a condition on the grant of federal moneys" to the states, "it must do so unambiguously." Pennhurst State School & Hosp. v. Halderman, 451 U.S. 1, 17 (1981) (citations omitted). Only if courts "insist[] that Congress speak with a clear voice" can the states "exercise their choice knowingly, cognizant of the consequences of their participation." (*Id.*) Although California believes Congress was clear in the past regarding its reimbursement duty to providers regarding section 1396a(n), at the minimum the provision is ambiguous and should not be interpreted against her under Pennhurst. In light of the Secretary's support for California's position, the Secretary's interpretation should be conclusive under Chevron U.S.A. Inc. v. National Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984).

The circuits could reject the Secretary's construction of the statute only if they were able to conclude that "Congress has directly spoken to the precise question at issue"; otherwise, "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." Chevron, 467 U.S. at 842-43 (1984) (emphasis supplied) (footnote omitted). The Kozlowski majority acknowledged that the Medicaid and Medicare acts were "among the most impenetrable texts within human experience" and provide "dense reading of the most tortuous kind." 42 F.3d at 1444. In this "'complex and highly technical regulatory program,'" deference "is all

the more warranted." Thomas Jefferson University v. Shalala, 512 U.S. 704, 710 (1994) (citation omitted).

Section 1396a(a)(10)(E) of Title 42 provides that a state plan "must" make Medicaid funds available for medical cost-sharing on behalf of QMBs. "Cost-sharing" is separately defined as including Part A deductibles and coinsurance. 42 U.S.C. 1396d(p)(3). The Petitioners read Section 1396a(a)(10)(E) and Section 1396d(p)(3) together as making it mandatory on the states to pay 100% of all reasonable charges for QMBs.

Yet if the Petitioners are correct in their reading, Section 1396a(n) -- which is entitled "Payment Amounts" and permits (but does not require) states to make payments in excess of the Medicaid ceiling -- would be entirely unnecessary, even though this section was enacted at the very same time, and in the same piece of legislation that created Section 1396a(a)(10(E).

Apart from this anomaly, the Petitioners' statutory reading is flawed. It is argued that, having used the word "must" in §1396a(a)(10)(E), Congress made mandatory the obligation on states to pay cost-sharing. The statutory language the Petitioners rely upon, however, does not mandate payment of coinsurance and deductibles in full, as the Petitioners would have it. Section 1396d(p)(3) is not addressed to the subject of payment amounts. It merely states that in certain circumstances the state is obliged to pay premiums and deductibles and coinsurance, without specifying whether the costs are to be paid in full, or are subject to the standard Medicaid limits.

Because Section 1396a(a)(10)(E) does not specify the amount of money a state is obliged to pay as coinsurance for QMBs and dual eligible, the Court must look elsewhere in the statute. Finding the relevant section is not hard: 42 U.S.C. 1396a(n), which was enacted in the same piece of legislation as Section 1396a(a)(10)(E), is entitled "Payment Amounts," and gives the states leave to limit reimbursement of coinsurance and deductibles to the ceiling set by Medicaid -- or in the alternative to pay the full 100%, as the state wishes. Section 1396a(n) is the answer to the question posed by this lawsuit -- not Section 1396a(a)(10)(E).

The two provisions may be reconciled by reading Section 1396a(a)(10)(E) to require that funds be available for coinsurance and deductibles only to the extent that a Medicaid plan under Section 1396a(n) provides for payments in excess of Medicare payments.

2. No review is appropriate because the circuits are not in confict over the merits of this case.

Rule 10.1(a) sets forth that reason for granting a petition for certiorari might be "[w]hen a United States court of appeals has rendered a decision in conflict with the decision of another United States court of appeals on the same matter." The Petitioners' fundamental ground for requesting certiorari from this court is that there is a conflict among the circuits because the court of appeals in Paramount and Beverly reached different conclusions than Kozlowski, Haynes, Snider, and Perales. This argument is fallacious. When the four cases were decided, the courts did not have the clarification provided by Congress. We do not know

what result these courts would have reached with this additional factor in mind. In any event, the two circuits post-section 4714 are consistent in holding that, when taken with the clarification from Congress, the better decision was that section 1396a(n) did authorize the states to make payments to providers at an amount less than the Medicare payment rate. For this reason, there is no conflict which warrants review by this court.

3. The "clarification" cannot be considered bogus by the argument that Congress shold have made the "clarification" as the Petitioners would have Congress do it.

The Petitioners argue strongly that the "clarification" of Congressional intent is bogus - that the Paramount and Beverly courts should have found that Congress did not clarify the law - it substantially changed the law. It is clear that Congress did intend to clarify the law. The title to section 4714(a) states that the amendment is a "clarification." Section 4714(c) states that the amendment relates back to "items and services furnished before [the date of the enactment of this Act] if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of enactment of this Act." The House Committee report recognizes a reimbursement gap between what the states and Medicare pays and expressly states that section 4714 "clarifies that state Medicaid program may limit Medicare cost-sharing to amounts that, within the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB."

The Petitioners press several arguments, in the face of Congress' explicit statement of clarification, to demonstrate that no clarification exists. They argue section 1396a(n) is unchanged in text as section 1396a(n)(1), that the cap is placed in a new subsection 1396a(n)(2), that three new provisions were enacted (i.e., that Medicare is "payment in full," that providers have no recourse against the beneficiaries, and that a third party may be liable for the payment gap) and that a clarification does not need an "effective" date. They also argue that it is probative that the "clarification" appears in a budget measure.

Petitioners' arguments beg the question. Congress' clarification tracks the interpretation California and the Secretary have taken regarding section 1396a(n). If Congress had not expressly stated it was clarifying the law, Petitioners' arguments might have some merit. Petitioners argument is that for Congress to have a true clarification it must legislate narrowly on the issue. Presumptively, if Congress had only enacted section 1396a(n)(2) and called it a clarification, Petitioners would have no complaint. The fact that Congress added provisions to make its original intent more workable or clear should not detract from its attempt to clarify the law.

The fact that section 4714 was enacted in a budget provision makes sense. The dispute is not over the coverage of benefits to poor people. The dispute is between providers, and the states and the federal government over the rates of reimbursement. The need for an effective date is reasonable. In the Snider, Perales, Haynes, and Kozlowski circuits, the providers are no longer to be paid at the Medicare rate. Congress wisely limited the impact of the clarification to

circuits which had pending lawsuits, not those in which the rights of the providers had become vested by virtue of a final judicial decision.

4. There is no "conflict" in this Court's decisions over the issue of the proper deference to be given a Congress' effort to clarify the law.

The Petitioners argue that a conflict exists between this Court's rule regarding the deference to be given Congressional enactments which purport to clarify the effect of prior law. In fact, that conflict does not exist or, if it does, it is hardly sufficient to justify this Court granting writs of certiorari to review these cases.

In Red Lion Broadcasting Co. v. FCC, 395 U.S. 381 (1968) this Court was confronted with a challenge by a licensee of the Federal Communications Commission to the "fairness doctrine." The FCC had interpreted the underlying statute by regulation which set forth the rule. Thirty years later Congress enacted a statement of the FCC rule under circumstances which the Court found to be a clarification of existing law. In such a case, this Court held:

> "Subsequent legislation declaring the intent of an earlier statute is entitled to great weight in statutory construction. And here this principle is given special force by the equally venerable principle that the construction of a statute by those charged with this execution should be followed unless there are compelling indications that it is wrong, especially when Congress has refused to alter the administration construction. Here, the

> Congress has not just kept its silence by refusing to overturn the administrative construction, but has ratified it with positive legislation. (Id. at 380-382 [footnotes omitted].)

This announcement of statutory construction in Red Lion Broadcasting fits the facts of these cases like a glove. The Secretary held to a long standing position that the states did not have to pay the full cost sharing amounts. Congress never altered the Secretary's interpretation. Later, Congress ratified that administrative construction with positive legislation by enacting section 4714. This Court in Red Lion Broadcasting pointed out that this principle of statutory construction was "venerable." (Id. at 381, n. 8.)

In Loving v. U.S., 517 U.S. 748, 116 S.Ct. 1737 (1996) this court repeated this "venerable" principle with approval but in a fact situation less applicable to the facts before this court.

The Petitioners create a false dilemma - that a conflict exists between two lines of authority of this Court and that only a resolution of that conflict in these cases can "clarify" the rule for subsequent cases. In order to advance that argument, the Petitioners contend that the line of cases exemplified by Public Employees Ret. System v. Betts, 492 U.S. 158 (1989) ("Betts") creates this conflict.

In Betts a disability retiree invoked a prohibition against age based discrimination under ERISA against a public employees retirement system which had insured her pursuant to a plan that pre-dated the discrimination provision. The critical question

was whether the plan was a "subterfuge" to avoid the prohibition. The retiree argued that certain statements by a house committee and by influential members of the Congress demonstrated its interpretation of "subterfuge" was appropriate.

This Court disagreed, commenting:

> "We have observed on more than one occasion that the interpretation given by one Congress (or a committee or Member thereof) to an earlier statute is of little assistance in discerning the meaning of that statute. (citations omitted) (Id. at 168.)

In Betts and the others cited by Petitioners, Congress does not act as a whole in enacting a specific clarification of a statute. It makes sense that whether Congress is ambivalent whether a clarification is intended (Gwaltney v. Chesapeake Bay Foundation, 484 U.S. 49, 63 n.4 (1988); ; South Dakota v. Yankton Sioux Tribe -- U.S.--, 118 S.Ct. 789 (1998)) when a house committee or a member of Congress purports to speak about past Congressional intent (Mackey v. Lanier Collection Agency & Serv., 486 U.S. 825, 839-840), that "little" assistance is rendered. However, when Congress amends the substantive statute in such a fashion that it unequivocally signals that it is clarifying what has been a statute subject to different interpretations, it makes sense that this Court should invoke that "venerable" rule of statutory construction that the judiciary should give Congress' enactment "heavy weight."

In summary, then, there is really no conflict between the two principles.

5. Beverly and Paramount determined that the statutory role given to section 1396a(n) scheme was ambiguous and therefore weight should be given to the clarification by Congress.

As variation on the Petitioners' attempt to see a conflict where none exists, the Petitioners argue that the Ninth Circuit and the court in Paramount should have first done a detailed analysis of the statutory scheme to demonstrate there was an ambiguity for which clarification was necessary (e.g., "the Ninth Circuit's decision failed to independently determine for itself either the meaning and intent of the 1986 QMB amendments or whether § 4714...was in any way a tenable reading of the legislation." (California Ambulance Ass'n at 21.)

What the Ninth Circuit did was to point out that various opinions had used different approaches to the proper interpretation of the statute, that the proper intent was not clear, and that section 1396a(n) was a baffling statutory provision. The Petitioners can not concede it was unclear how section 1396a(n) fit into Congress' scheme for providing benefits to QMBs. Once they make that concession, Chevron kicks in and they are lost. In any event, the Court did conclude that section 4714 was a tenable clarification of section 1396a(n) and that deference should be shown to Congress.

In Paramount, the court reached the same conclusion. Both circuit opinions must be read as agreeing that section 1396a(n) is puzzling and therefore they fulfilled whatever responsibility the Petitioners would impose upon them regarding the interpretation of

section 1396a(n). Consequently, the Petitioners do not establish that the circuit opinions lacked any condition precedent to their deference to Congress' clarification of the controversy.

6. Klein is not a ground for review under the facts of these actions.

The Petitioners' citation of United States v. Klein, 80 U.S. 128 (1872) as a basis for review is mystifying. The argument appears to be that Klein is relevant because section 4714 represents a "rule of decision" passed by Congress designed to intrude into the judicial province. The Petitioners then raise the specter of an Article III dilemma allegedly represented by section 4714 so that this Court will have the "...opportunity to provide direction to the lower courts by clarifying the scope of Klein." (Beverly pet. at 23.)

The Beverly decision does not mention the issue. Judge Posner talks about it in Paramount but never thought it sufficiently important to resolve the issue. That is easy to see why. In Klein Congress specifically attempted to change the law retroactively to avoid a decision of this Court, intruding into the powers reserved to the judiciary by Article III. Section 4714 does not represent a rule of decision. It is a clarification of the law that was in dispute. The rule of this Court is that when Congress provides clarification the judiciary gives great or little weight to that clarification depending upon the circumstances of the clarification. The Klein issue is simply not presented by this action.

The Petitioners harp on the argument that Congress enacted section 4714 in order to "decide the

controversy in [its] favor," quoting United States v. Sioux Nation, 448 U.S. 371, 404, 100 S. Ct. 2716, 2735-36, 65 L.Ed 2d 844 (1980) as somehow relevant. Unquestionably, Congress had the authority to decide the controversy in its favor prospectively by amending the statute. (Plant v. Spendthrift Farm, Inc, 514 U.S. 211, 218 (1995). In that sense, Congress decided the controversy in favor of the Secretary and the state. In Sioux Nation, this Court discussed Klein but did not reach the Klein issue. Accordingly, it is hard to see how Sioux Nation adds anything to the Petitioners' case. Moreover, when Congress enacts a clarification, by the nature of a clarification Congress is attempting to direct the outcome in a fashion Congress perceives to be in its "favor."

Finally, Congress did not attempt to impose a rule of decision upon the four circuits in which the courts - erroneously - held against the Secretary. The scope of its clarification only went to those circuits in which no provider had received any vested right by a final judicial decision. Accordingly, Congress never crossed over the separation of powers between the legislature and the judiciary.

7. No provider in California was promised payment by the state for crossover claims at 100% of what Medicare Providers charge.

This issue can not be reached by this Court unless it resolves the underlying dispute whether section 1396a(n) - pre-BBA - provided flexibility to the states to set the payment levels for Part A and Part B services below the Medicare charge levels for crossover claims.

In any event, from the perspective of California, this issue is contrived.

The Petitioners argue that "It is fundamentally unfair and constitutionally infirm for Congress to tell a provider who has been promised $100 to provide a service, that after providing the service, the rate has been changed after the fact to $80." (California Ambulance Ass'n at 30.)[2] No provider in California was under the illusion that it was promised $100 and then paid $80. Under Samuel, since 1983 all providers were on notice that California paid the Medicaid level of payment - not the Medicare level of what the providers charged.

In California, the relationship between the providers and California is a contract. (California Medical Assn. v. Lackner, 117 Cal.App. 3d 552, 560 (1981).) In California, "A statute fixing government payments may amount to an offer which, when accepted by performance, culminates in a contract between the government and the offeree." (internal quotation marks removed.) (Ibid.) Under this theory, Lackner held that the regulations - which are authorized by statute - of the Department constituted an offer and the providers acceptance of that offer - by providing services - constituted an implied contract. (Id. at 561.)

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2. The amicus brief filed by the American Medical Association argues that 4714 is unconstitutional under Eastern Enterprises v. Apfel, -- U.S. --, 118 S.Ct. 2131 (1998), contending that "the law's effect depends solely upon the confiscation of [physician's vested rights to payment under the prior statutory scheme]." (AMA Brief at 11.) Yet, in California the reasonable expectation of physicians was that they would be paid at the Medicaid rate. Consequently, Eastern Enterprises - aside from the fact the facts of the case have no resemblance to those of this action - does not apply.

Welfare and Institutions Code section 14109.5 clearly expressed the California policy - offer if you will - to providers that they would not be reimbursed at the rates they charged pursuant to Medicare for crossover claims. Consequently, no California provider of Part A or Part B services was promised $100 as the Petitioners claim.

CONCLUSION

The petitions should be denied. "[Section 1396a(n)] has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification." Beverly at 1266).

Dated: August 28, 1998

Respectfully submitted,

DANIEL E. LUNGREN
Attorney General of the State of California

CHARLTON G. HOLLAND, III
Senior Assistant Attorney General
Counsel of Record

Counsel for State Respondent

APPENDIX A

§ 14109. Determination of medical needs; inclusion of cost of deductibles or cost sharing charge

In determining the medical needs of any person eligible under this chapter, and the amount of health care such person is entitled to receive, the department shall include the cost of any deductibles or, cost sharing or similar charge imposed in connection with benefits to which such person may be entitled under the federal program of health insurance for the aged and disabled, except that for those individuals 65 years of age or over, who prior to July 1, 1973, were ineligible under the federal program of health insurance for the aged, the director may include such costs.

§ 14109.5. (1982) Limitation on reimbursement rate notwithstanding inclusion of cost of deductibles or cost sharing charge; change orders, expeditious implementation

Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter.

The fiscal intermediary shall expedite the implementation of any change order resulting only from this section. The department shall provide sufficient funding for any such change order to enable the fiscal intermediary to implement such change order expeditiously and to not have to divert staff or other resources from existing contract tasks, including but not limited to those resources dedicated to the implementation of all other change orders.

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Nos. 97-1947, 97-1949 and 97-2079

In the Supreme Court of the United States

OCTOBER TERM, 1997

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, DBA BEVERLY HOSPITAL, ET AL., PETITIONERS

v.

S. KIMBERLY BELSHÉ, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES

RICHARD GILMORE, M.D., ET AL., PETITIONERS

v.

DONNA E. SHALALA, ET AL.

CALIFORNIA AMBULANCE ASSOCIATION, ET AL., PETITIONERS

v.

DONNA E. SHALALA, ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION IN NOS. 97-1949 AND 97-2079 AND BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT IN NO. 97-1947

SETH P. WAXMAN
Solicitor General
Counsel of Record
FRANK W. HUNGER
Assistant Attorney General
BARBARA C. BIDDLE
ALISA B. KLEIN
Attorneys
Department of Justice
Washington, D.C. 20530-0001
(202) 514-2217

29 pp

QUESTION PRESENTED

Whether Section 4714 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 509-511, clarifies the States' payment obligations to providers of medical services to qualified Medicare beneficiaries, set forth in the prior version of the Medicaid Act, 42 U.S.C. 1396a(n) (1994 & Supp. II 1996).

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In the Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-1947

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, DBA BEVERLY HOSPITAL, ET AL., PETITIONERS

v.

S. KIMBERLY BELSHÉ, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES

No. 97-1949

RICHARD GILMORE, M.D., ET AL., PETITIONERS

v.

DONNA E. SHALALA, ET AL.

No. 97-2079

CALIFORNIA AMBULANCE ASSOCIATION, ET AL., PETITIONERS

v.

DONNA E. SHALALA, ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION IN NOS. 97-1949 AND 97-2079 AND BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT IN NO. 97-1947

OPINIONS BELOW

This brief is submitted by the Secretary of Health and Human Services in opposition to three petitions for

a writ of certiorari that seek review of the same judgment of the United States Court of Appeals for Ninth Circuit. The Secretary was named as a defendant in No. 97-1949 and No. 97-2079, but participated only as *amicus curiae* in No. 97-1947. The opinion of the court of appeals (97-1947 Pet. App. 1a-23a) is reported at 132 F.3d 1259. The opinions of the district court (97-1947 Pet. App. 24a-29a; 97-1949 Pet. App. 23a-31a; 97-2079 Pet. App. 26-28) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on December 2, 1997. 97-1947 Pet. App. 30a-32a. A petition for rehearing was denied on March 3, 1998. The petitions for a writ of certiorari were filed on June 1, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. Medicare is a federal program that provides for medical coverage for individuals who are disabled or at least 65 years of age, and who meet certain other eligibility requirements. Those persons are automatically enrolled in Part A of the Medicare program, a federally funded hospital insurance program. See 42 U.S.C. 1395 *et seq.* (1994 & Supp. II 1996). A provider of medical services to beneficiaries under Medicare Part A receives a significant portion of its fee from the federal government, which pays the provider from the Federal Hospital Insurance Trust Fund established by 42 U.S.C. 1395i.[1] The beneficiary is responsible for coin-

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[1] We use the term "provider" in this brief "in its colloquial sense rather than in its technical Medicare senses," as did the Seventh Circuit in the related case of *Paramount Health Systems,*

surance payments and deductible amounts. See 42 U.S.C. 1395e.

Persons who are covered by Medicare Part A (and certain other persons) may also purchase supplementary insurance for additional medical services under Part B of the Medicare program by paying a monthly premium to the Federal Supplementary Medical Insurance Trust Fund, which is established by 42 U.S.C. 1395t. A provider of medical services to beneficiaries under Medicare Part B receives a portion of its fee, typically 80% of the applicable fee schedule amount, from the Supplementary Medical Insurance Trust Fund. The beneficiaries of Part B services pay (in addition to premiums) coinsurance, copayments and deductible amounts. 42 U.S.C. 1395*l*(a)(1) and (b), 1395r.

b. The Medicaid program is a cooperative federal-state public assistance program that provides federal financial assistance (*i.e.*, federal matching funds) to States that elect to pay for medical services on behalf of certain needy individuals. See 42 U.S.C. 1396 *et seq.* (1994 & Supp. II 1996); *Harris* v. *McRae*, 448 U.S. 297, 301 (1980).[2] The Medicaid Act gives participating States discretion in setting the rates they will pay providers, within boundaries set by federal law. See 42 U.S.C. 1396a(a)(30). A participating State must submit a state plan, setting forth the fee schedule or methodology that the State will use in reimbursing providers, to the Secretary of Health and Human Services for ap-

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Inc. v. *Wright*, 138 F.3d 706, 706 (1998), petition for cert. pending, No. 97-2029.

[2] Federal financial participation is calculated according to a statutory formula that pays, at a minimum, 50% of the State's costs. 42 U.S.C. 1396b(a)(1), 1396d(b).

proval. See 42 U.S.C. 1396a(b). Providers generally must accept a State's payment for services covered under the Medicaid plan as payment in full, and may not seek to collect other than nominal payments for such services from the beneficiary or elsewhere. See 42 U.S.C. 1396*o*.

c. The Medicare and Medicaid Acts overlap in coverage for needy persons who are also elderly or disabled. Such individuals are often entitled to participate in Medicare Part A, but they may not be able to pay either the premiums needed to enroll in Medicare Part B or the coinsurance, copayments and deductibles for which they would be responsible under Parts A and B. To address that problem, Congress has required States participating in the Medicaid program to enter "buy-in" agreements with the Secretary of Health and Human Services. Under a buy-in agreement, the States use Medicaid funds to pay the Medicare Part B premiums on behalf of individuals who are eligible for both Medicare and Medicaid, and certain other persons who are eligible for Medicare but do not meet the general eligibility criteria for Medicaid coverage. See 42 U.S.C. 1395v, 1396d(a). As a result, the State's Medicaid program pays the Medicare premium, rather than the full medical expenses, of the elderly or disabled Medicaid-eligible persons, and these persons are then enrolled in the Medicare B program; the cost of their medical care thus is shifted in large part from the States' Medicaid programs to the federal government under Medicare.

Initially, the only persons eligible for this Medicare "cost-sharing" were those who met the qualifications for both Medicare and Medicaid services ("dual eligibles"). In 1986, Congress extended the class of persons eligible for the buy-in program to include individuals who have incomes below the federal poverty line but

who do not meet the income and assets qualifications for Medicaid eligibility. See Omnibus Budget Reconciliation Act of 1986 (OBRA), Pub. L. No. 99-509, § 9403, 100 Stat. 2053-2054. Members of this new class of individuals eligible for the buy-in program were called Qualified Medicare Beneficiaries, or "QMBs." See OBRA § 9403(b), 100 Stat. 2053. In 1988, Congress required States' Medicaid plans to buy-in to Medicare Part B for these individuals (as well as the "dual eligibles" who had been covered by buy-in agreements before 1986). Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748. Congress also redefined the statutory term "qualified medicare beneficiary" to include both the former group of QMBs (a group often called "pure" QMBs) and dual eligibles. Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8434, 102 Stat. 3805; see 42 U.S.C. 1396d(p)(1).

d. As noted above, Medicare Part B typically leaves individuals responsible for copayments, coinsurance, and deductible amounts. The elderly poor and disabled poor who are enrolled in Part B under the buy-in process (the QMBs) are often unable to meet such expenses. Congress has therefore required participating States' Medicaid plans to contribute towards those expenses on behalf of QMBs. See 42 U.S.C. 1396a(a)(10)(E)(i), 1396d(p)(3). The *amount* owed by the States to providers of medical services for those expenses is the subject of this dispute.

The Section of the Medicaid Act that governs the "contents" of state plans requires that a state plan for medical assistance must "provide * * * for making medical assistance [*i.e.*, Medicaid funds] available for medicare cost-sharing" for QMBs. 42 U.S.C. 1396a(a)(10)(E)(i). The Medicaid Act defines "medicare

cost-sharing" to include the specified premiums, coinsurance, copayments and deductibles owed under Medicare. 42 U.S.C. 1396d(p)(3).

Although Section 1396a(a)(10)(E)(i) thus requires States to make medical assistance available for Medicare cost-sharing for QMBs, that Section does not address the *amount* of cost-sharing to be paid by the States. A different Section, titled "Payment Amounts," addresses that issue. Before 1997, that Section provided:

> In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan *may provide payment* in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter [*i.e.*, Medicare] with respect to the service or item *exceeding the amount that is otherwise payable under the State plan* for the item or service for eligible individuals who are not qualified medicare beneficiaries.

42 U.S.C. 1396a(n) (emphasis added).

The Secretary of Health and Human Services read Section 1396a(n) to permit States to limit their cost-sharing payments to the amount (if any) by which the State's Medicaid rate for the service provided exceeded the amount that Medicare has paid, and has approved state plans that impose such a cap.[3] In essence, the Secretary permitted the States to limit their payments to the amount that they would have paid for QMBs'

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[3] It is undisputed that States must pay Part B premiums in full.

medical services under the Medicaid program, had they not been enrolled in Medicare, less the federal contribution made under Medicare. Providers of medical services argued, however, that the Medicaid and Medicare statutes required the States to pay those expenses in full. Four courts of appeals rejected the Secretary's construction of the Medicaid Act and ruled that the Act required States to pay the cost sharing in full. See *Rehabilitation Ass'n of Virginia, Inc.* v. *Kozlowski*, 42 F.3d 1444 (4th Cir. 1994), cert. denied, 516 U.S. 811 (1995) (*Kozlowski*); *Haynes Ambulance Serv., Inc.* v. *State of Alabama*, 36 F.3d 1074 (11th Cir. 1994) (per curiam) (*Haynes*); *Pennsylvania Med. Soc'y* v. *Snider*, 29 F.3d 886 (3d Cir. 1994) (*Snider*); *New York City Health & Hosps. Corp.* v. *Perales*, 954 F.2d 854 (2d Cir.), cert. denied, 506 U.S. 972 (1992) (*Perales*).[4]

Although those appellate courts each rejected the Secretary's construction of Section 1396a(n), they disagreed among themselves as to the precise rationale for the result that they had reached, see 97-1947 Pet. App. 20a, there were dissents from two of the appellate decisions, see *Kozlowski*, 42 F.3d at 1462-1472 (Niemeyer, J., dissenting); *Perales*, 954 F.2d at 863-869 (Cardamone, J., dissenting), and two district courts upheld the Secretary's construction even after *Kozlowski*, the last of the appellate decisions, was issued. See *Dameron Physicians Med. Group* v. *Shalala*, 961 F. Supp. 1326

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[4] The relevant state authorities filed petitions for a writ of certiorari in *Kozlowski* and *Perales*. In the government's responses to the certiorari petitions in those cases, we argued that, although we believed that the courts of appeals' decisions were wrong, the absence of a conflict among the circuits counseled against further review. See 94-1912 Gov't Br. in Opp. 7-12 (July 1995); 92-315 Gov't Br. in Opp. 7-9 (Oct. 1992).

(N.D. Cal. 1997); *Kulkarni* v. *Leean*, No. 96-C-884-S, 1997 WL 527674 (W.D. Wis. June 23, 1997).

e. In 1997, Congress enacted Section 4714 of the Balanced Budget Act, which amended 42 U.S.C. 1396a(n). Section 4714(a) is titled "Clarification Regarding State Liability For Medicare Cost-Sharing." See Balanced Budget Act of 1997 (BBA or 1997 Act), § 4714(a), Pub. L. No. 105-33, 111 Stat. 509. It provides that, in carrying out its cost-sharing obligations under Section 1396a(n), "a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that" such payments would exceed "the payment amount that would otherwise be made under the State [Medicaid] plan." 42 U.S.C. 1396a(n)(1)(B). Section 4714(a) thus expressly continues in effect the Secretary's longstanding position under the applicable Medicaid provisions as they existed before the enactment of the 1997 Act. As its title states, Section 4714(a) was enacted to "[c]larif[y] that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB." H.R. Conf. Rep. No. 217, 105th Cong., 2d Sess. 870-871 (1997).

Congress also provided that the clarification in Section 4714(a) would apply, not only prospectively, but also to payments for items and services rendered before the effective date of the clarification, if such payments were the subject of any lawsuit pending as of, or initiated after, the date of enactment. See BBA § 4714(c), 111 Stat. 511; 97-1947 Pet. App. 38a. The amendment does not apply, however, to payments that were the subject of cases challenging the Secretary's

interpretation of the Medicaid Act prior to passage of the 1997 Act that had been litigated to final judgment.

2. a. Before the 1997 amendments were passed, petitioners, who provide medical services to QMBs in California, brought these actions to compel the California Medicaid program to pay cost-sharing for QMBs in full. Petitioners challenged California's policy, reflected in state regulations and in a state plan approved by the Secretary, of limiting cost-sharing payments to the amount (if any) by which the California Medicaid rate exceeds what Medicare pays. Petitioners argued, *inter alia*, that the Medicaid Act required the State to pay cost-sharing in full.

The same district judge presided in each case. The district court granted petitioners' motions for summary judgment, following the Second, Third, and Eleventh Circuit decisions that had rejected the Secretary's construction of the Medicaid Act, and also adopting the "similar reasoning" of the Fourth Circuit, except in part. See 97-2079 Pet. App. 26-28; see also 97-1947 Pet. App. 27a-29a; 97-1949 Pet. App. 20a-23a.

b. The Secretary appealed the district court's decisions. After briefing on appeal was complete, Congress enacted Section 4714 of the Balanced Budget Act of 1997. In supplemental briefing, petitioners urged that Section 4714 changed rather than clarified the prior payment rules, and that the retroactive application of the new payment rules was unconstitutional.[5] The court of appeals reversed. It held that Section 4714 clarified the law, and that it therefore has no retro-

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[5] Petitioners did not dispute that the new law could be applied prospectively. See 97-1947 Pet. App. 18a.

active effect that might be called into constitutional question. 97-1947 Pet. App. 1a-23a.[6]

The court emphasized that "Congress expressly (and formally) stated as its intention that the new provision in [BBA] § 4714 was a 'clarification' of the payment rules contained in Section 1396a(n). It has been established law since nearly the beginning of the republic * * * that congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight." 97-1947 Pet. App. 18a. The court remarked that some of this Court's decisions have "question[ed] the competence of a later Congress to opine on the intended meaning of an earlier statute," but it observed that those decisions "involved attempts to use less formal types of subsequent legislative history, particularly Senate and House Committee Reports, to infer the meaning of prior enactments." *Ibid.* "By contrast, here Congress has formally declared [BBA] § 4714 to be a clarification of Section 1396a(n) in the title of the Act as well as in the Committee Reports." *Id.* at 19a.

The court rejected petitioners' argument that Section 4714(a) could not be a clarification of the law because it effected a substantial change in the law. That argument, the court held, failed to take account of the differences in rationales among the decisions construing Section 1396a(n); it also ignored the fact that "any quality of crystal clarity is uniformly recognized as

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[6] The court of appeals rejected petitioners' argument that Section 4714 does not apply to these cases because they were already on appeal when the Balanced Budget Act of 1997 was enacted, and therefore the cases were not "pending" within the meaning of Section 4714(c). See 97-1947 Pet. App. 16a-17a. That argument has not been renewed in this Court.

totally absent from the Medicaid and Medicare statutes," which have been characterized as "among the most completely impenetrable texts within human experience." 97-1947 Pet. App. 19a-20a. The court found Section 1396a(n) itself to be "a superb example of the baffling nature of the statute." *Id.* at 20a. "Given the extraordinary difficulty that the courts have found in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of Section 1396a(n) is worthy of real deference," and petitioners' arguments that the law changed rather than clarified the law "incorrectly presume a clearly established meaning for Section 1396a(n)—something that simply did not exist before [BBA] § 4714 was adopted." *Id.* at 20a-21a.

The court therefore "honor[ed]" Congress's express description of Section 4714(a) as a clarification of the law. 97-1947 Pet. App. 21a. That decision, observed the court, "moots all of [petitioners'] constitutional objections to the new legislation, because those objections rest entirely on the assertedly retroactive, rather than declaratory, nature of [BBA] § 4714." *Ibid.*

ARGUMENT

The court of appeals correctly concluded that Section 4714(a) of the Balanced Budget Act of 1997 clarified rather than changed existing law governing States' obligations under their Medicaid plans to pay for Medicare cost-sharing, and therefore raises no potential constitutional questions of retroactivity. That decision does not conflict with any decision of any other court of appeals, and it presents no issue of continuing importance. Furthermore, even if Section 4714(a) changed the law, petitioners' constitutional claims

would lack merit. Further review is therefore not warranted.

1. In enacting Section 4714(a), Congress ratified the Secretary's longstanding position that a State may limit its cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare pays for a given service. Because the Secretary's construction of prior law was correct and reasonable, Section 4714 did not change the law and therefore raises no questions of retroactivity.

"The power of an administrative agency to administer a congressionally created * * * program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress." *Morton* v. *Ruiz*, 415 U.S. 199, 231 (1974). Accordingly, as this Court held in *Chevron U.S.A. Inc.* v. *National Resources Defense Council, Inc.*, 467 U.S. 837 (1984), where Congress has not expressed its intention on a precise question at issue, courts should defer to a reasonable interpretation of the statute in question by the agency charged with administering the program under that statute. *Id.* at 844.

The Secretary's position on the extent of the States' cost-sharing obligations was reasonable. Section 1396a(a)(10)(E)(i) imposed upon the States the obligation to provide "for making medical assistance available for cost-sharing * * * for qualified medicare beneficiaries." That provision, however, did not specify any particular *amount* that States must make available for cost-sharing. Section 1396a(n), titled "Payment Amounts," did address the issue of amount, and provided that a State "may" pay cost-sharing even if the sum of the federal Medicare payment and the state payment exceeded the amount otherwise payable under

the state Medicaid plan to eligible individuals who are not QMBs. The Secretary reasonably construed Section 1396a(n) to permit, but not to require, States to pay cost-sharing in excess of the State's Medicaid rate. The Secretary's construction flowed naturally from the language of the Medicaid Act, since there was no other apparent reason for Congress to have provided in the Medicaid Act that a State "may" pay more cost-sharing than the difference between the State's Medicaid rate and the amount that Medicare pays.

Petitioners emphasize that three of the four courts of appeals that rejected the Secretary's construction of Section 1396a(n) read that provision as providing only that providers (or States) would not be penalized for accepting (or making) payments that, with the Medicare payment, exceeded the Medicaid rate. See *Perales*, 954 F.2d at 859; *Snider*, 29 F.3d at 895; *Haynes*, 36 F.3d at 1076. As the Seventh Circuit recently explained, however, those readings of the Medicaid Act are "undermined by the fact that if [as petitioners argue] * * * the statute *clearly* entitle[d] [petitioners] to reimbursement at Medicare rates, * * * the state [or provider] could hardly be penalized for such reimbursement. That would be penalizing it for complying with the statute." *Paramount Health Sys.* v. *Wright*, 138 F.3d 706, 709 (7th Cir. 1998), petition for cert. pending, No. 97-2029.[7] As Judge Niemeyer pointed out in his dissent in *Kozlowski*, "[i]t is utterly implausible * * * to believe that Congress would create a new section in the Act solely to acknowledge that it is permissible for states to do what

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[7] The petition pending in *Paramount* raises the same question as that presented here, and our response to that petition is being filed contemporaneously with this brief.

Congress *requires* them to do in other sections." 42 F.3d at 1469.

The Secretary's construction, moreover, comports with the purpose of the buy-in provisions, which is to relieve the States from the financial obligations that they would have to shoulder under their Medicaid plans if QMBs were not able to participate in the Medicare Part B program. Specifically, the Secretary's construction recognizes that, if the States did not buy QMBs into Medicare, the States would be required to pay for the medical care of at least those QMBs who are eligible for Medicaid, at whatever their Medicaid rates would allow. It is therefore reasonable to conclude that the States should not have to pay for medical services at a rate that is higher than the rate at which their own Medicaid plans would otherwise have required payment.

The legislative development of the provisions at issue further supports the reasonableness of the Secretary's construction. When Congress made buy-in coverage of all QMBs mandatory in 1988, the House Report accompanying the legislation specifically stated that States would not be required to make payments in excess of their Medicaid ceilings. See H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988). In 1989, Congress again amended the QMB provisions to "codif[y] the current practice with respect to dual eligibles and extend[] it to qualified Medicare beneficiaries." H.R. Rep. No. 247, 101st Cong., 1st Sess. 429 (1989). It did so, *inter alia*, by requiring physicians to accept assignments of claims from QMBs for the specific purpose of preventing physicians from exceeding the Medicaid ceilings by billing QMB patients directly for such additional amounts. *Ibid.*; see 42 U.S.C. 1395w-4(g)(3); Omnibus Budget Reconciliation Act of 1989, Pub. L. No.

101-239, § 6102(a), 103 Stat. 2169. Thus, Congress has treated QMBs principally as persons eligible for Medicaid benefits, but whose medical expenses are paid in large part by Medicare.

Even if the Medicaid Act is less than crystal clear on the extent of state Medicaid plans' obligations to pay for cost-sharing, it cannot be reasonably contended that the law was so clear and firmly settled against the Secretary's construction that Section 4714(a) must be viewed as a change in the law, despite Congress's express designation of it as a clarification. This Court, of course, had never considered the statutory question at issue. Although four circuits had rejected the Secretary's construction, they had not read the statutes in the same way, and neither the Seventh Circuit nor the Ninth Circuit—where the constitutional challenges to Section 4714(a) have been brought—addressed the statutory question. Two district courts had disagreed with the four circuits' construction of the Medicaid Act and had upheld the Secretary's position.

At a minimum, therefore, the Medicaid Act was "a hopeless muddle so far as [QMB] reimbursement [was] concerned." *Paramount*, 138 F.3d at 711; see also *Kozlowski*, 42 F.3d at 1450 (describing provisions governing Medicaid and Medicare financing as "among the most impenetrable texts within human experience"); 97-1947 Pet. App. 19a-20a (decision below; same). "[T]he fact that well-intentioned and intelligent experts at legal exegesis have arrived at three or four seemingly plausible readings of a particular text may be the best evidence that this interpretive puzzle has no definitive answer." *Kozlowski*, 42 F.3d at 1462-1463 (Niemeyer, J., dissenting). Under these circumstances, Congress's designation of Section 4714(a) as a clarifi-

cation, rather than a change, of the States' obligations under the Medicaid Act, deserves deference.

2. Petitioners urge the Court to grant certiorari to clarify how much weight should be given to a congressional interpretation of prior law, as reflected in a statutory amendment. Petitioners argue that there is tension in this Court's precedents addressing the issue. See 97-1947 Pet. 12-17; 97-1949 Pet. 18-21; 97-2079 Pet. 18-23. That issue is not presented in this case, however, because the Secretary reasonably construed the prior law to arrive at the result that Congress subsequently directed in Section 4714(a). Accordingly, the question of the weight owed to Congress's view, as expressed in Section 4714(a), that the new statute is a "clarification," is academic. At the least, this Court could not reject Congress's view that Section 4714 clarifies prior law without first analyzing the complex and now-superseded pre-1997 framework governing state payment of cost-sharing for QMBs, and determining whether the Secretary's construction of those provisions would have been owed deference under *Chevron*. That antecedent question of statutory interpretation, however, is of no continuing importance.

Moreover, the asserted tension in this Court's decisions is illusory. This Court has stated that express congressional declarations in *legislation* about the meaning of an earlier statute are given great weight, but that statements in "subsequent legislative history" such as committee reports about the meaning of earlier legislation are not. Compare, *e.g.*, *Loving* v. *United States*, 517 U.S. 748, 769-770 (1996) (legislation), and *Red Lion Broad. Co.* v. *FCC*, 395 U.S. 367, 380-381 (1969) (same); with, *e.g.*, *Public Employees Retirement Sys.* v. *Betts*, 492 U.S. 158, 167-168 (1989) (legislative history); *Gwaltney of Smithfield, Ltd.* v. *Chesapeake*

Bay Found., 484 U.S. 49, 63 n.4 (1987) (same); *Consumer Prod. Safety Comm'n* v. *GTE Sylvania*, 447 U.S. 102, 116-118 & n.13 (1980) (same); *United States* v. *Philadelphia Nat'l Bank*, 374 U.S. 321, 348-349 (1963) (same); and *United States* v. *United Mine Workers*, 330 U.S. 258, 281-282 (1947) (same).

In its *Paramount* decision, the Seventh Circuit identified two cases, *South Dakota* v. *Yankton Sioux Tribe*, 118 S. Ct. 789 (1998), and *Rainwater* v. *United States*, 356 U.S. 590 (1958), in which this Court declined to give weight to subsequent legislation in construing earlier enactments. See *Paramount*, 138 F.3d at 711. These cases are readily reconciled with the *Loving* line of authority. In *Yankton Sioux Tribe*, the subsequent legislative materials made contradictory statements about the effect of the prior law at issue, and the Court therefore declined to give those materials significant weight. See 118 S. Ct. at 804 (emphasizing that legislative record "reveals no consistent, or even dominant, approach to the territory in question, and it carries but little force in light of the strong textual and contemporaneous evidence of diminishment") (internal quotation marks omitted). Although the Court did state in that case that "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one," see *id.* at 803 (quoting *Philadelphia Nat'l Bank*, 374 U.S. at 348-349), it did not suggest that subsequent legislation should never be given heed in determining the scope of an earlier law passed by Congress.

Rainwater involved the applicability of the False Claims Act to civil claims against a wholly owned government corporation. It was argued in that case that Congress's amendment of the criminal (but not the civil) provisions of the Act in 1918, to cover "any corporation in which the United States of America is a

stockholder," suggested that the 1863 Congress that enacted the False Claims Act did not intend it to apply to any government corporations. The Court found the 1918 legislation not probative of the scope of the original Act because the amendment was evidently concerned with different kinds of corporations, in which the government might have an ownership interest, and not wholly owned government corporations. See *Rainwater*, 356 U.S. at 593-594. The Court did not suggest that subsequent legislation is *per se* irrelevant to the scope of an earlier statute; rather, it simply found the subsequent legislation in that case not probative.

This case is readily distinguishable from *Rainwater* and *Yankton*. In this case, Congress has unmistakably addressed the precise statutory question at hand in legislation. Petitioners therefore do not dispute that, prospectively at least, the amendments made by Section 4714(a) definitively define the scope of States' cost-sharing obligations. Under these circumstances, the lower court correctly concluded that Congress's clarification of Section 1396a(n) in 1997 deserved great deference in defining the earlier scope of that law.[8]

3. Petitioners argue that Section 4714 effects an unconstitutionally retroactive change in the law gov-

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[8] The Seventh Circuit expressed concern that the *Loving* line of cases would permit an unsuccessful litigant to obtain a "'clarifying' amendment that would reverse the interpretation that the district court had given to [a] statute, *even if that meaning was crystal clear*" before the amendment. *Paramount*, 138 F.3d at 710 (emphasis added). That concern was misplaced, because nothing in the *Loving* line suggests that Congress could in that way alter the meaning of a "crystal clear" statute. Nor is that concern presented here: by the Seventh Circuit's own characterization, the prior rules governing QMB reimbursement were not "crystal clear" but a "hopeless muddle." *Id.* at 711.

erning the States' cost-sharing obligations to providers under the Medicaid Act. That contention, however, necessarily depends on petitioners' characterization of Section 4714(a) as a change in the law rather than a clarification. Because, as we have explained, Section 4714(a) did clarify prior law, petitioners' constitutional arguments are not properly presented. For the same reason, the court of appeals had no occasion to address petitioners' constitutional arguments.

Even if petitioners' constitutional challenges were properly presented, they would lack merit. Petitioners first argue that the application of Section 4714 to their cases would violate the separation of powers principle set forth in *United States* v. *Klein*, 80 U.S. (13 Wall.) 128 (1872), by directing the outcomes of their cases. See 97-1947 Pet. 17-24; 97-1949 Pet. 21-25. This Court has made clear, however, that "[w]hatever the precise scope of *Klein*, * * * its prohibition does not take hold when Congress 'amend[s] applicable law.'" *Plaut* v. *Spendthrift Farm, Inc.*, 514 U.S. 211, 218 (1995) (quoting *Robertson* v. *Seattle Audubon Soc'y*, 503 U.S. 429, 441 (1992)). Without question, Section 4714(a) amended the law applicable to States' cost-sharing obligations to providers of medical services, and did not simply direct the outcomes of these particular cases. That point is underscored by the fact that Section 4714's amendment to Section 1396a(n) applies prospectively as well as to pending cases. Section 4714 therefore "*did* amend applicable law," *Seattle Audubon Soc'y*, 503 U.S. at 441, and *Klein* has no relevance to this case.

Petitioners' takings and due process challenges to Section 4714 under the Fifth Amendment are also without merit. As explained above, under Medicaid, the States, with the financial assistance of the federal government's matching funds, provide medical assis-

tance to the needy. The Secretary read the pre-1997 Medicaid Act to permit States to limit their cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare would pay for a given service. California had chosen to exercise that option in its state plan. Even if Section 4714 changed the law, the change simply ratified the payment rules already set forth in California law; it did not change the amount that the *federal government* would pay providers. Because Section 4714 did not affect any contractual obligation of the federal government to petitioners, the cases on which they principally rely concerning contractual obligations of the federal government to private parties, *United States* v. *Winstar Corp.*, 518 U.S. 839 (1996), *Perry* v. *United States*, 294 U.S. 330 (1935), and *Lynch* v. *United States*, 292 U.S. 571 (1934), are inapposite.[9]

Thus, the only question is whether Section 4714 effected an unconstitutional taking or violated due process if (by hypothesis) it reduced the amount of cost-sharing that the States legally owed providers for services already rendered. As this Court recently reaffirmed, "a party challenging governmental action as an unconstitutional taking bears a substantial burden." *Eastern Enterprises* v. *Apfel*, 118 S. Ct. 2131, 2146

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[9] Petitioners' assertion that Congress made Section 4714 retroactive to save matching funds is both irrelevant and unsupported. Matching funds are owed to States, not to providers (see 42 U.S.C. 1396b (1994 & Supp. II 1996)); they do not affect the amount of compensation that providers receive for their services from the States. Moreover, Section 4714(a) is permissive. If all the States choose to pay cost-sharing in full, the federal government would still match those payments. Thus, any savings of matching funds would be, at most, "merely incidental" to Congress's regulatory objectives. See *Winstar*, 518 U.S. at 898.

(1998) (plurality opinion); see *id.* at 2156-2157 (Kennedy, J., concurring in the judgment and dissenting in part). Although a plurality of the Court in *Eastern Enterprises* held that the statute under review there effected an unconstitutional taking without just compensation, five members of the Court explicitly disagreed with that conclusion. In any event, the plurality did not disavow any of the Court's earlier takings cases reaffirming that Congress has "considerable leeway" (*id.* at 2149) in enacting social and economic legislation, even if that legislation has a retroactive effect. See *id.* at 2147-2149 (discussing *Connolly* v. *Pension Benefit Guar. Corp.*, 475 U.S. 211 (1986), and *Concrete Pipe & Prods. of Cal.* v. *Construction Laborers Pension Trust for Southern Cal.*, 508 U.S. 602 (1993)).

Application of that settled jurisprudence leads to the conclusion that Section 4714 is constitutional. In determining whether governmental regulation amounts to a taking, this Court considers the economic impact of the regulation, its interference with investment-backed expectations, and the character of the governmental action. See, *e.g.*, *Eastern Enterprises*, 118 S. Ct. at 2146 (plurality opinion); *Connolly*, 475 U.S. at 224-225. All three factors point to a conclusion that Section 4714(a) did not effect a taking. As for the economic impact of the legislation, whereas one plaintiff in *Connolly* had been assessed nearly 25% of that firm's net worth, see 475 U.S. at 222, petitioners have made no effort to show that Section 4714 would have a comparable economic impact on them. On the issue of investment-backed expectations, the law challenged in *Connolly* expanded the employers' obligation to pay benefits, even though those employers had contracts expressly limiting their obligations to pay benefits. See *id.* at 218. In contrast, the California Medicaid plan put petitioners on notice

that payment would be limited to the amount by which California's Medicaid rate exceeded what Medicare pays. See *California Med. Ass'n* v. *Lackner*, 172 Cal. Rptr. 815, 819 (Ct. App. 1981) (California Medicaid rules constitute a promise to pay providers "*at the rates set forth therein*") (emphasis added). Thus, at the time petitioners provided medical services, they had only their hope that their contested reading of the Medicaid Act would ultimately prevail and supersede their contracts with the State. Finally, as for the character of the government regulation at stake, Section 4714, like the statute upheld in *Connolly*, does not permit the government to "physically invade or permanently appropriate any of the [petitioners'] assets for its own use," *Connolly*, 475 U.S. at 225, nor does it have a severely retroactive effect out of proportion to petitioners' own experience, cf. *Eastern Enterprises*, 118 S. Ct. at 2149-2150 (plurality opinion). Petitioners' takings claim is therefore without basis.

Petitioners' due process challenge is similarly without merit. That argument ignores Congress's broad power to enact legislation "adjusting the benefits and burdens of economic life" and to make such legislation retroactive. *Usery* v. *Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976). Such legislation comes to a court "with a presumption of constitutionality, and * * * the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way." *Ibid.* Retroactive economic legislation passes due process scrutiny as long as "the retroactive application of the legislation is itself justified by a rational legislative purpose." *Pension Benefit Guar. Corp.* v. *R.A. Gray & Co.*, 467 U.S. 717, 730 (1984).

Congress plainly had rational bases for making Section 4714 retroactive. First, Section 4714 conformed federal law to the state-law contract between providers and those States (like California) that had limited their cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare paid. Second, Section 4714 conformed the law to the States' expectations, which were formed by the Secretary's longstanding construction of the Medicaid Act and by the Secretary's approval of state plans adhering to that construction. Finally, it was rational for Congress simply to "correct the unexpected results" of the decisions that rejected the Secretary's construction of Section 1396a(n). *General Motors Corp.* v. *Romein*, 503 U.S. 181, 191 (1992). Petitioners' due process challenge thus lacks merit.[10]

CONCLUSION

The petitions for a writ of certiorari should be denied.

Respectfully submitted.

SETH P. WAXMAN
Solicitor General
FRANK W. HUNGER
Assistant Attorney General
BARBARA C. BIDDLE
ALISA B. KLEIN
Attorneys

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[10] Petitioner Gilmore asserts that retroactive application of Section 4714 violates the Contract Clause. See 97-1949 Pet. 25-28. It is well established, however, that Congress is not subject to the requirements of the Contract Clause. See, *e.g.*, *R.A. Gray*, 467 U.S. at 732-733.

(4) (5)

Nos. 97-1947 and 97-2079

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

BEVERLY COMMUNITY HOSPITAL ASSOCIATION DBA BEVERLY HOSPITAL, ET AL.,

Petitioners

v.

S. KIMBERLY BELSHE, Director of the California Department of Health Services, ET AL.,

Respondents

CALIFORNIA AMBULANCE ASS'N and CALIFORNIA MEDICAL ASS'N, ET AL.,

Petitioners

v.

S. KIMBERLY BELSHE, Director of the California Department of Health Services, ET AL.,

Respondents

On Petitions for Writ of Certiorari To The United States Court of Appeals For The Ninth Circuit

JOINT REPLY TO BRIEFS IN OPPOSITION

JOHN R. HELLOW
Counsel of Record
BYRON J. GROSS
HOOPER, LUNDY & BOOKMAN, INC.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067
(310) 551-8111
Counsel for Petitioners, No. 97-1947

WILLIAM J. BUSH
Counsel of Record
CRAIG J. CANNIZZO
ROBERT L. RUSKY
HANSON, BRIDGETT, MARCUS, VLAHOS & RUDY
333 Market Street, Suite 2300
San Francisco, CA 94105
(415) 777-3200
Counsel for Petitioners, No. 97-2079

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INTRODUCTION

As the petitions establish, review is warranted because these cases present an important issue of statutory interpretation that has split six of the circuits, *i.e.*, the appropriate rate of reimbursement for providers of medical services to qualified Medicare beneficiaries ("QMBs") under the Medicare and Medicaid Acts, an issue of enormous financial consequences because it involves potential recoupment of amounts approaching $400 million in fees previously paid by the Medi-Cal program for medical services already rendered. Equally important, review is also necessary to resolve the jurisprudential question that directly caused the split, *i.e.*, given the courts' Constitutional duty to ascertain the meaning and intent of legislation, what deference is owed to a statute passed by later Congress which purports to clarify the meaning of a statute enacted by an earlier Congress, especially when Congress directs retroactivity only as to litigants.

Petitioners contend that because the two circuits faced with the deference issue became so entangled in deciding how much deference should be given, they failed to recognize the necessity of first ascertaining the intent of the Congress that enacted the original law, a task that lies solely within the purview and jurisdiction of the courts, not Congress. *Pierce v. Underwood*, 487 U.S. 552, 566 (1988). Guided by doctrines those courts interpreted to require controlling deference to the 1997 Congress' clarification of the 1986 Medicare legislation, neither the Ninth nor the Seventh Circuits engaged in any meaningful examination of the 1986 QMB legislation at issue here, including 42 U.S.C. §1396a(n) – the section that the 1997 Congress purported to clarify.

As if to underscore the Ninth and Seventh Circuits' failures to address the meaning and intent of the 1986 legislation, respondents made their discussion of these statutes a cornerstone of their opposition to the petitions in this case. However, in their effort to convince this Court that the "clarifying statute", §4714 of the Balanced Budget Act ("BBA") of 1997, correctly reflects the 1986 Congress' original intent, respondents present an inaccurate and misleading exposition of the Congressional intent be-

hind the QMB legislation and the administrative construction of the earlier "dual eligible" and QMB programs. Since these inaccuracies may directly impact this Court's determination whether further review is appropriate, petitioners address them here.

DISCUSSION

A. The Secretary Materially Misstates the Intent of the 1986 Legislation

The Secretary states, without citing any authority, that the purpose of the QMB legislation was "to relieve the States from the financial obligation that they would have to shoulder under their Medicaid plans if QMBs were not able to participate in the Medicare Part B program." Brief of Federal Respondent ("Brf. F.R."), p. 14. As the four circuits that did address the intent and purpose of the 1986 QMB legislation made clear, Congress' intent was to protect beneficiaries, not the states.

To begin with, in 1986, when Congress enacted the original QMB statutes, including the later-clarified §1396a(n), the states had no obligation under Medicaid to shoulder any financial obligations for QMBs if the latter were unable to participate in the Medicare Part B program because, by definition, QMBs were *not* eligible for Medicaid. Indeed, as the House Energy and Commerce Committee's Report reveals, the "devastating financial burden" faced by millions of the elderly poor was the crux of the problem Congress sought to address:

> that 20 percent of our senior citizens – 5 million people – *are without Medicaid* or private insurance to supplement their Medicare benefits. These beneficiaries, relying on Medicare alone to finance needed health services, are among the sickest and poorest of our senior and disabled citizens. They face substantial out-of-pocket costs for needed care and can incur devastating financial burdens when illness strikes.

H.R. Rep. No. 99-727, 99th Cong., 2d Sess., 102-03 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3692-93 (emphasis added).

To aid and assist this segment of the elderly poor, the House

Committee drafted two sections of a bill that provided two options for healthcare coverage. The first, §4602, identical to its counterpart in the Senate, which later became §9402 of Pub. L. 99-509, allowed states to expand eligibility for the full range of Medicaid benefits for the elderly and disabled with incomes up to the poverty line. The second option, which became §9403 of Pub. L. 99-509 and contained the QMB provisions at issue here, offered states the more limited option of paying only the Medicare Part B premium and the other Part B cost-sharing requirements for Medicare beneficiaries who met a state's threshold requirements and fell below the Federal poverty line. *Id.*, at 105-6, *reprinted in* 1986 U.S.C.A.N.N. at 3695-96..

The legislative history demonstrates quite clearly that the purpose of the buy-in provisions was not, as the Secretary contends, "to relieve the States" from non-existent Medicaid financial obligations to QMBs unable to pay for Part B benefits. To the contrary, Congress was trying to induce states to provide limited Medicare gap-filling benefits for this class of the elderly poor.

The Secretary also erroneously claims that her "construction recognizes that, if the States did not buy QMBs into Medicare, the States would be required to pay for the medical care of at least those QMBs who are eligible for Medicaid, at whatever their Medicaid rates would allow." Brf. F.R., p. 14. This construction cannot be a proper interpretation of the 1986 QMB legislation because if the states elected not to participate in the QMB program, they were not otherwise required to pay for QMBs who were, at that time, by definition not Medicaid eligible. Pub. L. No. 99-509, §9403, 100 Stat. 1874, 2054-55 (codified as amended at §1396a(a)(10)(E)).

Having erroneously postulated that the states might have to incur Medicaid obligations for at least some of the QMBs who could not participate in the Medicare Part B program, the Secretary opines that it is "reasonable to conclude that the States should not have to pay for medical services at a rate that is higher than the rate at which their own Medicaid plans would otherwise have required payment." Brf. F.R., p.14. But the statutory language and the legislative history demonstrates that

Congress intended that for those qualified *Medicare* beneficiaries who would not be eligible under §9403 for full *Medicaid* benefits, *Medicare* cost-sharing would be exactly what the name implies, *i.e.*, a full sharing of *Medicare* costs and *Medicare* benefits for *Medicare* beneficiaries. *See Pennsylvania Medicaid Soc. v. Snider*, 29 F.3rd 886, 899 (3rd Cir. 1994) ("*Snider*"); *see* also H.R. Rep. No. 99-727, at 104, 106, *reprinted in* 1986 U.S.C.C.A.N. 3607, 3694, 3696.

Had either the Ninth or Seventh Circuits engaged in a true analysis of the meaning and intent of the 1986 legislation, as had the four other circuits that addressed this issue, they would have similarly determined that the 1997 BBA amendments, like the Secretary's position here, were at odds with the intent of the 1986 legislation and could not constitute a "clarification" to which any deference is owed. Instead, the Ninth Circuit merely observed that the courts had encountered "extraordinary difficulty in discovering the intent of the original Congress" and on that basis concluded that Congress' 1997 "clarification" of §1396a(n) was worthy of "real deference." *Beverly Community Hospital Ass'n v. Belshe*, 132 F.3d 1259, 1266 (9th Cir. 1997) ("*Beverly*"). However, "[c]omplexity alone is not enough to trigger *Chevron* [deference]." *Snider*, *supra*, 29 F.3d at 902. Petitioners have elsewhere shown that this deference was not warranted. The Seventh Circuit was properly, but not sufficiently, skeptical in evaluating the same purported "clarification":

> The location of the 1997 amendments in a statute labeled the "Balanced Budget Act" and concerned primarily with cutting the federal deficit hardly creates confidence that Congress was, court-like, interpreting the 1986 statute. It is far more realistic to regard the 1997 QMB provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government. Nothing in the provisions themselves suggests a process of interpretation; they merely declare that the states are not required to reimburse QMB providers at the Medicare rate.

Paramount Health Services, Inc. v. Wright, 138 F.3rd 706, 710 (7th Cir. 1998)).

Nowhere in its opinion does the Ninth Circuit explain how it concluded that §4714's provisions are a "statement of what §1396a(n) had meant all along." *Beverly*, 132 F.3d at 1266. Indeed, nowhere does that court engage in an analysis of the meaning and intent of the 1986 QMB legislation so as to justify its assertion.

The Ninth Circuit's avoidance of any independent determination of the intent of the 1986 legislation through the deference it uncritically accorded the 1997 "clarification" only underscores the importance of this case. Supreme Court review is necessary to resolve the apparent conflict in this Court's decisions as to the judicial "deference" owed to subsequent congressional "clarifications" in light of the fundamental principle that the judiciary, not Congress, is entrusted under the Constitution with the *independent* duty to interpret the meaning and intent of federal legislation. *See City of Boerne v. Flores*, ___ U.S. ___, 138 L.Ed. 2d 624 (1997).

B. Post-Enactment Legislative History

Respondents attempt to bolster their erroneous view of the intent of the 1986 Legislation by an equally mistaken and selective review of its post-enactment history.

1. 1988. Respondents first rely on selected language contained in a Health Energy and Commerce Report accompanying the Medicare Catastrophic Coverage Act of 1988, which referred to the Committee's understanding of the "practice" of some states to limit their Medicare cost-sharing payments. H.R. Rep. No. 100-105(II), 100th Cong., 2d Sess., 61 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 884. Respondents ignore, however, that the same House Report elsewhere states in discussions of its version of the bill: "States would be required to pay the Medicare premiums, deductibles and co-insurance for all Medicare enrollees with incomes at or below the federal poverty guideline and assets at or below twice the supplemental security income guidelines." *Id.*, at 36, 1988 U.S.C.C.A.N. 857, 859. Furthermore, nothing in the three other reports accompanying the 1988 legislation, including a House Ways and Means Committee re-

port, a Senate report, and a House Conference report, indicates that either the full House or the Senate agreed with the Energy and Commerce Committee's initial comments. Indeed, the House Ways and Means Committee noted that for QMBs, states would be *required* "to pay the Medicare premium, deductibles and co-insurance [amounts]." H.R. Rep. No. 100-105(I), 100th Cong., 2d Sess., 6 (1988), 253, *reprinted in* 1988 U.S.C.C.A.N. 803, 808. The final Conference agreement accompanying the legislation did not incorporate any discussion similar to that Respondents rely upon, but instead referenced and reaffirmed the language in the Ways and Means Report. H.R. Conf. Rep. No. 100-661, 100th Cong., 2d Sess., 253 (1988), *reprinted in* 1988 U.S.C.C.A.N. 923, 1031.

Most important, the legislation ultimately passed in 1988 did not modify the payment provisions enacted in 1986 relating to QMBs in 42 U.S.C. §§1396d(p) and 1396a(n); it merely deleted two phrases that had previously made the State's Medicaid program's participation in the QMB program optional. Pub. L. No. 100-360, §301(a)(1), 102 Stat. 683, 748. Accordingly, whatever the House Energy and Commerce Committee meant by its inconsistent report language did not materialize in the form of actual legislation in 1988. [1] *See Rehabilitation Ass'n. of Virginia v. Kozlowski*, 42 F.3d 1444, 1458 (4th Cir. 1994), *cert. den.* 516 U.S. 811 (1995) ("*Kozlowski*") ["the only way to change a law is to actually change a law, not to drop contrary language into committee reports addressing totally unrelated provisions"].

Because of all of this, which Respondents fail to disclose in their opposition, coupled with this Court's general warning regarding the troublesome nature of subsequent legislative history,[2] neither the Second Circuit in *New York City Health & Hosp.*

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[1] Because the report language purports to describe the "practice" of some states under the "dual-eligible" program which was repealed in 1988, it certainly has little value in interpreting §1396a(a)10)(E) or §1396d(p)(3) as to the scope of the states' obligations to make payments for Medicare cost-sharing. *Snider*, 29 F.3d at 898.

[2] *See Pierce v. Underwood*, 487 U.S. 552, 566 (1988); *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 116-20 (1980); *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979).

Corp. v. Perales, 954 F.2d 854, 861 (2nd Cir.), *cert. den.* 506 U.S. 973 (1992) ("*Perales*"), nor the Third Circuit in *Snider*, 29 F.3d at 894, nor the Fourth Circuit in *Kozlowski*, 42 F.3d at 1457, were willing to accept the one inconsistent snippet of post-enactment legislative history contained in the 1988 House Energy and Commerce Committee Report as an indication that Congress intended to enact a wrenching change of its original intent in establishing the "dual eligible" and QMB programs as unambiguously set forth in their *contemporaneous* legislative history, which expressly and specifically stated that the states had to provide full payment for Medicare cost-sharing. *Kozlowski*, 42 F.3d at 1457. *See* S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C.A.N. 1943, 2020; H.R. Rep. No. 99-727, at 106, *reprinted in* 1986 U.S.C.C.A.N. at 3696.

2. 1989. The Secretary notes that in 1989, Congress amended the QMB provisions by requiring physicians to accept assignment of claims from QMBs. Pub. L. No. 101-239, §6102(a), 103 Stat. 3805. Relying on an alleged State practice of limiting reimbursement of providers of "dual eligibles" to the Medicaid rate, the Secretary claims that the "specific purpose" of this new legislation was to prevent physicians from exceeding the Medicaid ceilings by billing QMBs for such additional amounts. Brf. F.R., p. 14. The Secretary is wrong.

First, the legislation she describes as "amended ... QMB provisions" is neither an amendment nor is it principally related to the QMB program. Section 1848 of the Social Security Act was added through §6102 of the Omnibus Budget Recovery Act of 1989 ("OBRA '89") as comprehensive physician payment reform under Part B of the Medicare program. Section 6102 created a relative value-based fee schedule for payment by Medicare to Medicare "participating" physicians, replacing the prior charge based system, and established a series of limits for charge reimbursement that applies to physicians not accepting assignments under Medicare that significantly circumscribes their ability to pursue payments from Medicare beneficiaries *above* the *Medicare coinsurance and deductible* amounts (commonly referred to as "balance billing"). H.R. Conf. Rep. No. 101-386, 101st Cong., 1st Sess., 738-63, *reprinted in* 1989 U.S.C.C.A.N.

at 3341-65.

As part of the limitation against "balance billing" by "nonparticipating" physicians, Congress prohibited billing on other than a Medicare assignment-related basis, in the case of QMBs and other dual eligibles. 42 U.S.C. §1395w-4(g)(3). Thus, just as with participating physicians, nonparticipating physicians providing services to QMBs are only entitled to payment of Medicare coinsurance and deductibles, in addition to Medicare's payment, and may not balance bill the patients for any difference between their charges and the Medicare fee schedule.

Second, the Conference Report that accompanied this provision states: "Further, assignment is mandated for all claims submitted for beneficiaries for whom *Medicaid is required to pay Medicare cost-sharing charges*." H.R. Conf. Rep. No. 101-386 at 761, *reprinted in* 1989 U.S.C.C.A.N. at 3364. This statement from the Conference Committee does not reflect any understanding of the practice of some state Medicaid programs of eliminating or reducing Medicare cost-sharing for "dual eligibles" that is even remotely similar to the earlier and gratuitous statements of the House Budget Committee in H.R. Rep. No. 101-247, 101st Cong., 1st Sess., 247, *reprinted in* 1989 U.S.C.C.A.N 1906, 2090, at least as that report is characterized by the Secretary. It also makes clear that QMBs are principally Medicare, not Medicaid beneficiaries, given that it is Medicare cost-sharing that must be paid.[3]

Consequently, in her brief, the Secretary has mischaracterized the nature and context of the 1989 legislation, and has ignored the relevant legislative history from the Conference Committee explaining the limited purpose of the 1989 amendments.

C. Lack of Any Longstanding Policy

The Secretary claims that §4714(a) confirms her longstand-

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[3] Additionally, the House Committee commentary, written more than 20 years after the enactment of §1396a(a)(15) (now repealed) dealing with "dual eligibles" did not purport to construe the statute; it only referred to the "practice" of some states and, therefore, carries little weight. *Perales*, 954 F.2d 854, 861; *Snider*, 29 F.3d 886, 900-01; *Kozlowski*, 42 F.3d 1444, 1458.

ing position before the enactment of the 1997 Act that a state could limit or eliminate Medicare cost-sharing by utilizing the state's Medicaid payment "caps." Two courts, however, have found the Secretary did not have a longstanding consistent position, but, in fact, had previously adopted a contrary position to the one assumed for purposes of the litigation, thereby eroding the deference normally to be afforded. *Perales*, 954 F.2d at 862; *Snider*, 29 F.3d at 902. As to Part B benefits, petitioners have demonstrated that the Secretary's present "litigation inspired" position of 9 years (1989-98), dating from the beginning of the QMB litigation, is both shorter than and directly contrary to her previous longer-standing position of 18 years (1971-89). Calif. Ambulance Ass'n, et al., Pet. for Cert., pp. 6-7. In regulations published in 1987 under 42 U.S.C. §1396a(a)(15) of the Act, the Secretary made it clear that the State's option to pay less than full cost-sharing was limited to a nominal amount "to be paid by the Medicaid recipient ... reasonably related to the recipient's income and resources." 42 C.F.R. §431.626(a)(5). These regulations remain in effect today.

With respect to Part A payments in California, one may describe the Secretary's position as firmly rooted in shifting sand. From the beginning of the Medicare and Medicaid programs, until it changed its policy as of May 1, 1994, California paid the full amount of cost-sharing payments for Part A services. In May of 1994, it adopted a new policy to pay *none* of the Medicare cost-sharing for Part A services, even when the State's Medi-Cal rate exceeded the amount paid by Medicare.[4] This is contrasted with the Secretary's currently-stated policy that "a State may limit its cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare pays for a given service." Brf. F.R., p. 12. According to the

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[4] In regard to Part A, the Secretary misstates the facts when she asserts that "[p]etitioners challenged California's policy, reflected in state regulations and in a state plan approved by the Secretary, of limiting cost-sharing payments to the amount (if any) by which the California Medicaid rate exceeds what Medicare pays." Brf. F.R., p. 9. In fact, the policy challenged by petitioners in *Beverly* provided that California would not pay cost-sharing in any circumstances.

State's policy, it will not pay any of the cost-sharing. Nevertheless, the Secretary approved the State's Plan Amendment incorporating this policy in February 1996. Beverly Community Hospital Ass'n, Appellant's Brief, Exh. 1. Subsequently, when §4714 made it clear that a State must make cost-sharing payments up to its Medicaid rate, the Secretary changed her position and informed California that the policy to make zero payments in all cases was not acceptable. *Id.*, Pet. Reh., at 11 n. 11. The Secretary's change in attitude about the extent of the State's obligation shows clearly that she has not had a longstanding, consistent policy of any sort. *See INS v. Cordoza-Fonseca*, 480 U.S. 421, 446 n. 30 (1987) ["An agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is entitled to considerably less deference than a consistently held agency view"].

CONCLUSION

To paraphrase this Court, when the political branches of the Government act against the background of judicial interpretations of federal statutes already issued through the enactment of retroactive "clarifying" legislation, there is a risk that vital principles necessary to maintain separation of powers and the federal balance will be lost. Petitioners respectfully urge that the *writ of certiorari* issue to review the judgment of the Ninth Circuit in this matter.

Respectfully submitted,

John R. Hellow
Counsel of Record
Byron J. Gross
Hooper, Lundy & Bookman, Inc.
1875 Century Park East, Suite 1600
Los Angeles, CA 90067
(310) 551-8111
Counsel for Petitioners

Respectfully submitted,

William J. Bush
Counsel of Record
Craig J. Cannizzo
Robert L. Rusky
Hanson, Bridgett, Marcus, Vlahos & Rudy
333 Market Street, Suite 2300
San Francisco, CA 94105
(415) 777-3200
Counsel for Petitioners